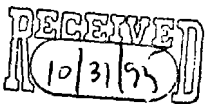
CSSP



PLAN INTERNATIONAL
SANTO DOMINGO, DOMINICAN REPUBLIC

MID-TERM EVALUATIONREPORT
CHILD SURVIVALIX PROJECT
PLAN/AID

Evaluation Team:

Ramón J. Soto H., M.D.,M.H.S.
Gustavo I. Tapia R., M.D., M.Sc.
Elizabeth Gómez, M.D.,M.P.H..Ph.D.

JULY 1995

TABLE OF CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS

AID	United States Agency for International Development
ARI	Acute Respiratory Infections
BF	Breastfeeding
CDD/ORT	Control of Diarrhea1 Diseases/Oral Rehydration Therapy
CEN	Cenrro de Educación Nutritional (Center for Nutritional Education)
CHW	Community Health Workers
CMC	Club de Madres Carinosas (Caring Mothers Club)
CONASUMI	Consorcio National de Supervivencia Materno-Infantil (National Maternal-Child Survival Consortium)
c s	Child Survival
cs IX	Child Survival IX Project
DIP	Detailed Implementation Plan
EPI	Expanded Program of Immunizations
FUCES	Fundación Cultural y Educativa en Salud (Foundation for Health Education and Culture)
HIS	Health Information System
IDAN	Instituto Dominicano de Alimentacion y Nutrición (Dominican Institute for Feeding and Nutrition)
KPC	Survey of Knowledge, Practices and Coverage
MH/BS	Maternal Health/Birth Spacing
MOH	Ministry of Health
N/GM	Nutrition/Growth Monitoring
NGOs	Nongovernmental Organizations
ORS	Oral Rehydration Salts
ORU	Oral Rehydration Unit
PAHO	Pan American Health Organization
PDS	Proveedores Directos de Salud (Direct Health Providers - Physicians, Nurses)
PLAN	PLAN International/Santo Domingo
PSI	Proyecto de Supervivencia Infantil IX (Child Survival IX Project, or cs IX)
PVS	Promotores Voluntarios de Salud (Community Health Workers, or CHW)
ROCCA	PLAN Regional Office for the Caribbean and Central America
SENUTRI	Servicios de Nutrición Comunitaria (Community Nutrition Services)
SILOS	Sistema Local de Salud (Local Health System)
THA	Technical Health Assistants
UNICEF	United Nations Childrens Fund

ACKNOWLEDGEMENTS

We wish to extend our sincere gratitude and acknowledgement to the field, administrative and management staff of PLAN/Santo Domingo for all of the support they provided during the implementation of this evaluation.

Special recognition is due to Mr. Rezene Tesfamarian, PLAN/Dominican Republic Country Director, for his constant interest and feedback; to Dr. Francisco Fernández, Health Coordinator, who provided continuous support during the evaluation process; to Rafael Miranda and Adalberto Rodriguez, without whose assistance it would not have been possible to obtain such excellent reports from the focus groups conducted; to Daysi Rosado for her invaluable support in the implementation of the KPC survey; and to Baris Calderón, who manually reviewed the questionnaires.

We are grateful to the community, to the community health workers and to the community leaders for their spontaneous cooperation and participation in the process, especially with regard to feedback, as well as to the institutional staff of the Ministry of Public Health and Social Welfare.

EXECUTIVE SUMMARY

The evaluation team consisted of an evaluation expert from the Dominican Republic (Dr. Elizabeth Gómez, M.D., Ph.D.), who dealt with issues involving the HIS, supervision and referral; the ROCCA Health Coordinator (Dr. Gustavo Tapia, M.D., M.Sc.), who was responsible for conducting the KPC survey that measures the effectiveness of the CS IX; and an expatriate external evaluator (Dr. Ramón J. Soto, M.D., M.H.S.), who evaluated the remaining issues enumerated in the appropriate AID guidelines.

The evaluation took place between July 10 and July 29, 1995. Costs were estimated at US$13,500, broken down as follows: 62% for evaluator costs, including fees and other expenses, and 38% for operating expenses: including payments to surveyors, transportation expense and feedback. Site visits were made to six CS IX operating areas, including seven health facilities and eight local organizations.

Both qualitative techniques, such as focus groups and formal interviews, as well as quantitative techniques, such as the KPC survey and forms for assessing the availability of supplies (see Annex 5) were used in the evaluation.

The salient achievements of the CS IX are as follows:

Technical development of specific skills and knowledge in the area of child survival for responsible personnel (THAs, CHWs), as well as, to a lesser extent. for other providers, such as physicians in both public and private practice.

Facilitation of educational materials formally field-tested with coordination and technical support provided by CONASUMI and the MOH.

Organization of the CMCs as self-help groups for conducting promotional and educational activities in the areas of maternal health, birth spacing and breastfeeding. The clubs have become a true community model for working to achieve the sustainability of activities, while undergoing a process of strengthening and increased autonomy.

Success in maintaining a high degree of enthusiasm among the CHWs through the implementation of a system of incentives. This system needs to be revised in order to eliminate monetary incentives and strengthen such other aspects as are related to continuous training, sense of community belonging, and timely deliver} of appropriate supplies and materials.

Regular contributions of funds by PLAN have facilitated the procurement of furniture, equipment and drugs to strengthen local health facilities. These

contributions have been an appropriate complement to CS IX training, education and coordination strategies.

Lessons learned can be summarized as follows: the need for broad-based participation by the involved sectors and for the latter to begin receiving benefits from the very outset of the CS IX planning and implementation process, which should involve all of the technical and administrative staff of the NGO, in order to generate a sense of commitment and empowerment. The lack of feedback and use of the information by management at the various levels, including the community level. limits the coordination of efforts and the potential for synergy and contributes to service inefficiency and ineffectiveness.

The following recommendations are considered to be the key importance:

The relevance and quality of the CS IX should be based on a capacitating process of coordination and transfer of technical and management skills and knowledge in both local organizations and the MOH. The initiative being taken by a number of different organizations, including PLAN, to develop a pilot SILOS in the area of Herrera represents an auspicious opportunity.

In order to ensure appropriate transfer of responsibility. credibility criteria need to be defined for local organizations, based on their legal status, degree of community representativeness, proven prior experience, and organizational structure, among other factors.

CS IX activities will be more relevant if community structures such as the CMCs are strengthened; if exchange and analysis of information among the various local health providers is promoted; if the CHWs are empowered to discuss and properly analyze the information that they gather. not only from individuals but also from family groups; and if promotional activities are increased through the appropriate use of all available media (but in particular through one-on-one encounters).

Strengthen the organizational structure of the CMCs, as a genuine community group with the ability to promote sustainable education and promotion activities through peer interaction.

There is a need to promote a more participative process for information analysis (by the community). The ability to analyze information for decision-making purposes needs to be further strengthened.

In view of the underutilization of budgeted funds, as well as the static approach employed with regard to the number of beneficiaries, it is recommended that a

dynamic approach be adopted that will make it possible to capture a greater percentage of the target population, within existing budget limitations.

Feedback sessions were held with PLAN staff members, the Country Director, and representatives of the MOH and local organizations. The results of the evaluation should be shared with any individual groups and organizations with which PLAN has had a significant degree of coordination.

I. INTRODUCTION

The Child Survival IX Project (Proyecto de Supervision Infantil), or CS IX is being implemented in the periurban area of Herrera, in the western sector of the city of Santo Domingo, capital of the Dominican Republic. The neighborhoods included in the project have been subdivided, for operational purposes, into six areas: Altagracia (consisting of the barrios of El Palmar, El Abanico and Altagracia); Buenos Aires (barrio of Buenos Aires); Duarte (barrios of Las Palmas, San Francisco and Duarte); Enriquillo (barrios of Enriquillo, La Venta, Los Transformadores and Los Pinos); Libertador (barrios of Libertador and Holguin Abajo); and Los Coquitos (barrios of Los Coquitos and Aeropuerto Viejo). These areas of influence contain a population of some 154,320.

The area is characterized by broken terrain and most dwellings are located along streams, which have become dumping sites for both solid and liquid waste. The constant migratory flow of families (estimated at between 10 and 20% annually) in search of better economic conditions and the prevalence of low levels of schooling are additional factors negatively impacting on the appropriate implementation of CS activities.

The residents of these areas come primarily from rural or periurban areas of other provinces in the country. This particular population group has a high rate of unemployment, which has led to an increase in the intensity of informal commercial activities (street vendors). A Reproductive Health and Family Planning Survey conducted by the Instituto Dominicano de Desarrollo Integral (Dominican Integrated Development Institute) in February 1994 reports an illiteracy rate of 10.6% among women between the ages of 15 and 49.

The CS IX has a coverage of 2,933 children under age 2 and 6,167 women between the ages of 14 and 49. According to the HIS, 35 1 pregnancies have been recorded as of July 1995.

There are no hospitals operating in the area. There are two MOH health subcenters; the subcenter operating in Las Caobas provides outpatient and specialized care in the area of emergency services and minor surgery, while the one located in Engombe has 40 beds and provides basic specialized services. In addition, the MOH has in operation three peripheral clinics providing care in the areas of general medical services, pediatrics and gyneco-obstetrics (La Banderita in Buenos Aires, Inocencio Diaz Piñeyro in Altagracia, and Libertador in Libertador).

There are also a number of private clinics and doctors ' offices, as well as clinics operating in NGOs and community organizations, most of which are staffed by medical personnel paid for by the MOH. Most of the medical staff hold two or more positions in

the public or private sectors, thus affecting their availability in the health facilities. Registered nurses are quite scarce and are engaged primarily in clinical work.

Neighborhood organizations and groups reflect a variety of different forms of organization: some have been conducting activities regularly for between 10 and 20 years and have available schools, health clinics and other services.

There are currently in operation some 20 community organizations with a more or less solid structural base that conduct athletic, cultural, educational and/or health activities on a smaller scale. Most have bylaws, but very few actually have legal status or have been formally recognized as local NGOs. There are two umbrella associations for neighborhood groups: the Asociación de Organizaciones de Herrera (Association of Organizations of Herrera), whose membership base consists of 14 neighborhood groups. and the Patronato, which includes 10 neighborhood groups. From a structural standpoint, however, both are still quite weak.

PLAN currently participates in a committee sponsored by the MOH, to which advisory services are provided by PAHO, for coordinating the efforts of organizations working in Herrera and Engombe. Its objective is to establish on a pilot basis a Local Health System (Sistema Local de Salud, or SILOS) in the area. Among others, the following organizations participate in this initiative: the Autonomous University. of Santo Domingo, the Dominican Social Security Institute, and the Association of Businessmen of Herrera.

II. METHODOLOGY

In consultation with the Health Coordinator from the PLAN Regional Office for the Caribbean and Central America (ROCCA) and the PLAN/Santo Domingo Health Coordinator, a work plan was developed to guide the evaluation process. Following analysis of tasks related specifically to the implementation of the survey of knowledge, practices and coverages (KPC) that was carried out simultaneously, the necessary adjustments were made to the plan (see Annex 2, Work Plan).

The evaluation team was divided into three subteams to cover the various areas identified by AID:

Subteams	Members of the Subteams	Areas Covered by Each Subteam
Qualitative Evaluation Team	Leader: External Evaluation Specialist Members: CS IX Health Coordinator, THA	1. Achievements: Inputs and outputs 2. Importance to Development 3. Design and Implementation 5. Sustainability
KPC Survey Team	Leader: ROCCA Health Coordinator Members: MOH Representative and THA	1. Achievements: Results 2. Effectiveness
HIS Team	Leader: Local External Evaluation Specialist Members: Employee in Charge of the HIS, THA	4.2 Data Management and Use 4.7 Supervision and Monitoring 4.11 Referral Linkages

Data collection was conducted using both qualitative and quantitative techniques. Following a review of available documents and preliminary interviews with staff from the PLAN Field Office, a determination was made as to which key actors would provide the required information.

Information was obtained from the following key actors: THAs, CHWs, PDSs (medical staff of MOH and local organization health facilities); managers of central-level MOH Maternal and Child Health Programs; Key Community Informants (leaders of popular

organizations, directors of local NGOs, members of CMCs); and members of CONASUMI.

Guidelines were designed for conducting focus groups with these individuals, as well as for interviewing institutional personnel and community residents. A summary instrument was also developed for gathering data from local health facilities with regard to essential materials and supplies, together with a test of knowledge of CS for PDSs (see Annex 5).

Focus groups were held as follows:

The focus groups for THAs were held in the offices of PLAN with the participation of the six supervisors, while the focus groups for CHWs were held in the Las Palmas community center with the participation of nine CHWs. Four physicians attended the focus group for PDSs (one from the MOH Peripheral Clinic and three who worked in health centers attached to local organizations). In the focus group for CMCs, five mothers participated; this focus group was also held in the Las Palmas community center, as was the case with the focus group for CHWs. All focus group sessions were coordinated by a rapporteur who took notes; in addition, all sessions were tape-recorded.

The interviews with key institutional informants took place in the offices of the MOH and CONASUMI. Community leaders were interviewed in their homes or at community sites. Annex 4 contains the list of individuals contacted, together with their organizations and positions.

The evaluation team toured CS IX neighborhoods in the areas of Herrera and Altagracia. Visits were made to seven health facilities (the MOH Clinica Periferica Diaz Piñeyro; the Centro Medico de1 Ayuntamiento y Junta de Vecinos, in the neighborhood of Holguín/Enriquillo; Clinica Libertador; Community Clinic in El Palmar de Herr-era; Centro Medico de1 Centro de Educación Popular; the Dispensario Medico in Fuces; and the Las Palmas Health Center).

The data collection forms contained items listed in the AID guidelines for conducting mid-term evaluations of CS IX child survival projects, as well as items of specific interest to PLAN International that might help enhance the volume of lessons learned and recommendations for future action.

The qualitative information gathered was subsequently systematized through the use of key words, which made it possible to extract data related to the sustainability of the activities carried out under the project.

A review of available documents was also made (see Annex 3).

The specific methodology for conducting the KPC survey is described in Annex 1.

Lastly, support was provided for the programming and implementarion of feedback meetings with PLAN staff members, community representatives, institutional health care providers, and others.

III. MID-TERM EVALUATIONFINDINGS

This section contains answers to the questions formulated in the 1995 BHR/PVC Child Survival Mid-Term Evaluation Guidelines for CS IX three-year projects.

1. Accomplishments Recorded

Implementation of the CS IX began on September 1, 1993 ; the project has thus been in operation for 22 months to date. According to the DIP, the project was to be based on three strategies: training, education and coordination.

The training strategy was to provide training by levels in order to ensure the proper application of the various CS IX interventions (Immunizations, CDD/ORT, ARI, BF, Nutrition/Growth Monitoring, and Maternal Health/Birth Spacing). The levels referred to involve the THAs, CHWs, CMC Coordinators and health personnel of health care facilities located in the area of influence of the CS IX.

Education was to be the strategy for transferring knowledge and modifying the behaviors of mothers of children under age two and pregnant women. Toward this end, the home visit was chosen as the preferred operational technique. The home visit is the primary task carried out by CHWs.

Lastly, coordination was to involve establishing communication, collaboration and joint implementation of CS IX activities with community organizations, local NGOs and the MOH with a view toward leveraging efforts and transferring knowledge and technologies to these organizations. In this way, the potential sustainability of the CS IX would be ensured.

Training. Through the month of July, 1995, the CS IX had conducted 85 training courses, workshops or seminars. Training events show the following distribution, broken down by intervention: ARI, 16 (19%); CDD/ORT, 15 (18%); Immunizations, 14 (16%); BF, 12 (14%); N/GM, 8 (9%); and MH/BS, 23 (27%). The remaining training events have focused on topics involving teamwork, educational techniques, and strategies based on primary health care and community participation.

The DIP does not specify a level of intensity for each intervention. However, the Annual Report provides the following percentages: CDD/ORT, 20%: ARI. 20%; N/GM, 20%: Immunizations. 20%; and MH/BS, 20%. The percentages listed in the preceding paragraph reflect a high concentration of effort on training in the areas of MH/BS and N/GM when combined with BF, followed by ARI, CDD/ORT and Immunizations.

Education. A series of informational meetings and supervised practice sessions have been held for mothers in the CMCs, especially as regards aspects of BF and MH/BS. According to the mothers, these sessions are held at regular intervals (every 15 days). During the sessions, participative techniques and individual testimony are used. As a rule, the CHWs serve as facilitators. The presence of the MOH staff member responsible for breastfeeding promotion at the national level, who has given a number of talks and coordinated practice sessions for CMC mothers, has been quite beneficial, as expressed by mothers, CHWs and THAs. The Annual Report (October 1994) indicates that 50 meetings had been held with mothers at the level of the CMCs, together with 15 training courses, to the direct benefit of 618 mothers.

A significant volume of educational materials has been produced under the CS IX, including handbooks for CHWs and medical personnel, posters, pamphlets and flyers (see Table 1). These materials have become one of the essential tools of the CHWs in making their home visits. For further details regarding supplies and materials, see section 4.5

Table 1. Printed Educational Materials by Type and Intervention
Period: May 1994 -July 1995

Type	ARI*	CDD/ORT	MH/BS	BF	N/GM+	Immunizations *
Posters	2700	200	10,000		2,500	
Overheads	1,500					
PAHO for ARI Modules	550					
Flipcharts		200	200	200		
Pamphlets	25,000	5,000**				
CHW Handbook		200	200	350		
Vaccination Handbook						12.000
PAHO Handbook for Physicians	350	350				

* Materials designed and field-tested by PAHO/MOH are reproduced for dissemination,
** Field-tested by PLAN in coordination with UNICEF/MOH.

+ Field tested by SENUTRI and IDAN.
The rest of the materials are designed and field-tested by CONASUMI/CESPAS.

Using the framework provided in the DIP, the outputs and results obtained are described below in summary fashion by individual intervention:

IMMUNIZATIONS

Vaccines have been available on a daily basis in seven permanent health posts (MOH and neighborhood health clinics). Nine additional sites are also in operation but have vaccines available only on specified days. Support has been provided for the national vaccination campaigns sponsored by the Ministry of Health. The MOH has supplied biologicals and, on occasion, syringes. PLAN has used its regular funds to purchase three of the four refrigerators programmed.

Fourteen courses on vaccinations have been held. The following have received training: 150 CHWs (97% of the projected number) and 6 THAs (100%); none of the staff of the MOH local health facilities have received training.

Seven permanent vaccination posts are in operation, providing vaccination service on a daily basis (47 % of the projected goal), although an additional nine posts offer vaccinations on scheduled days only.

CDD/ORT

PLAN has provided the following: training for 6 THAs (for supervision of CHWs); 28,000 packets of ORS (51% of the programmed amount), and informational materials. PLAN has coordinated with the MOH for the training of medical and nursing staff from the health services. However, as a result of logistical and physical space constraints, the four ORUs scheduled for implementation under the CS IX have not yet been installed. With regard to the CMCs, there are no coordinators, as a result of which no results are presented. This is true for the rest of the interventions described here.

Training has been provided to 150 CHWs (97% of the projected figure) and to 40 MOH and NGO physicians (100% compliance). It is important to point out that the relative instability of medical personnel in MOH health facilities constitutes a constraint that has made it necessary to schedule new training courses for recently hired staff.

N/GM

PLAN has complied with the contributions idenrified in the DIP with regard to training of THAs, supervision for CHWs, and procurement of 95 of the 155 scales, as well as purchase of vitamin A and antiparasitic drugs and reproduction of educational materials.

The results obtained are as follows: 156 CHWs trained in aspects of nutrition and growth monitoring for children under age 2 (100% of the established amount), plus 6 THAs and CHWs trained in education for nutritional recovery. The three Nutritional Education Centers have not yet been installed, but the equipment and materials have already been procured. The latter are in the process of being installed in the FUCES health center and in the headquarters of the women's group operating in Barrio Holguin.

MH/BS

Twenty-three courses in maternal health and birth spacing have been conducted, through which training has been provided to 150 CHWs and 6 THAs. In addition. 11 physicians were trained in aspects of family planning. PLAN has purchased with its own regular funds iron, folic acid and calcium tablets, which are distributed to health centers operating under the auspices of the MOH, NGOs and neighborhood organizations. Educational materials have also been reproduced (see Table 1).

AR1

PLAN has provided the following: training courses for its own staff (6 THAs who carry out supervisory activities), procurement of antibiotics for local health facilities, and educational materials. Training activities have been coordinated with the MOH so that training can be provided to the trainers of medical personnel. Training has been provided to 100% of CHWs in case prevention, diagnosis and referral and 20 physicians have been trained in the diagnosis and treatment of pneumonia. In addition, educational and informational materials have been reproduced for distribution to the community, CHWs and physicians (see Table 1).

OTHER PROJECT INTERVENTIONS

The matching funds that PLAN has provided have been allocated to activities designed to improve water and drainage networks and garbage collection in the project area.

The objectives as stated in the DIP are as follows: 1) repair the water system in 20% of project beneficiary households, 2) 60% of the families will use chlorinated water or water filters, 3) latrines or drainage filters will be constructed in 20% of beneficiary households, 4) drainage will be provided for 50% of the standing water in the area, and 5) improvements will be made to the garbage collection system in 20% of project beneficiary households.

With regard to the above, the HIS provides some data: as of July 1995. 97 (2%) of the households in the CS IX area of influence do not have latrines or other appropriate methods for disposing of excreta. Some 51% (2,496) of households have access to a

latrine or common toilet. Forty-seven percent (2,277 households) have either a latrine or private or semi-private toilet. With regard to garbage collection, fewer than 2% of households have municipal garbage collection service, as 60% of the households dump their garbage in streams while 38% burn it.

1,069 water filters have been delivered, primarily to households affiliated with PLAN. Twenty-seven percent of the households have access to residential water service (inside the home), while 48% have access to water taps located within 10 meters of the home and 18% have access to public water taps.

2. Effectiveness

To determine the effectiveness of the various CS IX interventions. a survey of knowledge, practices and coverage was designed and implemented. The results are presented in Annex 1.

3. Relevance to Development

PLAN has carried out a series of initiatives aimed at empowering the beneficiary population to participate in CS IX activities and take advantage of the services offered by the project.

Forty-four Caring Mothers Clubs (CMCs) have been organized. These clubs become self-help groups for providing counseling and training in various aspects of BF and MH/BS. However, the organizational structure of these clubs is weak, as there is no one to act as coordinator of the mothers. The continuity of the CMC has been dependent primarily on the specific efforts of the CHWs and THAs, without which the CMC. would cease to function.

Through home visits, the CHWs provide education to mothers with regard to the benefits of the CS IX. while actively promoting and encouraging use of the services it makes available. It is important to point out that some of the physicians working in local health facilities, and especially those from the private sector, convey messages that contradict those promoted by the CS IX. This leads to confusion among the mothers with respect to the messages provided to them by the CHWs, thus offsetting any possible benefits.

The above-described situation was identified by the CS IX, as a result of which the process for training and motivating CHWs was intensified. In this regard. CS IX credibility is now at a peak according to a number of the CHWs and mothers interviewed, as a result of which many mothers have now decided IO follow the advice given by the CHWs.

No use is made of the valuable information recorded by the CHWs through their home visits in the form of feedback to the communities, especially by the management staff of local organizations.

4. Design and Implementation

4.1 Design. The CS IX has kept unchanged the area of influence and target population as described in the DIP. Coverage has not increased even though the approved budget for fiscal year 1995 has been underutilized to date (see section 4.13). In other words, the project has maintained a static goal in terms of target population.

Following the recommendations of the DIP Review Committee, adjustments were made to the attainable objectives, taking into account the fact that the area of Altagracia had not been subject to any interventions under the preceding CS IX V. Further details in this regard are provided in the Child Survival IX Project Annual Report.

The flowchart showing the linkages between health providers in the area of influence of the CS IX (see the graphic entitled Linkages between Health Providers in the Area of PLAN/Santo Domingo, attached hereto as an annex) was also designed. In the opinion of the providers (CHWs and physicians working in local health centers), there has been little practical progress in the proposed linkages.

This can be explained by the following: the CHWs continue to maintain direct linkages with the PLAN THAs; the information generated by the CHWs is not disseminated, much less analyzed at the local level in coordination with the rest of the local organizations and providers; the mothers clubs continue to be affected by weak organizational structure; MOH leadership is quite poor at the local level: and many of the CHWs are not affiliated with any local organization.

In addition, from the outset the CS IX has adopted a vertical orientation that has been reinforced by a PLAN-dependent health team. The implications of this are that there are two parallel PLAN structures working in the communities: the structure used by the sponsorship program and the structure used for health interventions. So far, it has not been possible to integrate these two structures at the local level in order to leverage benefits for the target population.

4.2 Data Management and Use. The HIS is primarily a data gathering and reporting system, the use of which is somewhat important for decision-making and of little import with regard to analysis of the information being processed.

The HIS depends exclusively on data recorded daily by the CHWs on the family card during their home visits. The information produced with this data is consolidated by the

CHW. However, it is not used by any of the three higher decision-making levels: THA, Health Coordinator, and CS IX management and funding agencies.

Following a detailed review process (THA, Health Coordinator), the family card is forwarded to the data processing center, where it is input at the close of every month. This card is the most important, and only, source of data for the HIS.

Based on the data recorded on the family card, consolidated reports are produced monthly, broken down by levels, for the eight intervention areas of the CS IX: 1) Immunizations, 2) CDD/ORT, 3) Growth Monitoring, 4) Breastfeeding, 5) Maternal Health and Birth Spacing, 6) ARI, 7) Household Characteristics, and 8) Demographic Data (age and sex).

Also produced are lists of pregnant women and undernourished children by CHW or THA area, as required, and reports indicating the number of active families per CHW, which are used for feedback and special follow-up actions.

The global consolidated reports are prepared in triplicate and forwarded to the Health Coordinator and director, with one copy theoretically transmitted to the community organizations. (The latter is not currently taking place).

The CHW correctly uses the criteria of at-risk individuals for making decisions regarding number of visits, counseling to be provided, referrals, etc. The CHWs have no tools available for communicating to community organizations the health status of the areas in which they work.

Emphasis has been on the selection of indicators, and consequently the form on which the data are consolidated is based on such indicators.

The indicators used consist primarily of event counts. Although most of the statistics are based on data related to beneficiary (target) population, no indicators are provided that would make it possible to assess activities implemented versus activities planned.

The information produced by the HIS is essentially descriptive, and thus does not allow supervisors to interpret the information to determine whether it has any potential significance and, in the event that it does, to decide what needs to be done.

The system at the level of the central office is entirely computerized as regards the inputting and processing of data. Actual and potential users do not by themselves interact with the HIS, but rather do so by means of requests for reports that they submit to the staff of the data processing center.

One of the THAs has been named coordinator of activities involving the HIS (responsible specifically for collecting and returning family cards to the CHWs and for organizing training events).

Design of the computer screen formats for data entry is optimal. Although it is easy to navigate through the menu options on the computerized HIS to obtain output (reports), users do not have direct access to the computer to obtain such reports.

Given the degree of automation attained with regard to the report production, the usefulness of the monthly reports prepared manually by the CHWs is not clear, as these reports are not designed to facilitate decision-making with regard to the tasks performed and services provided by the CHW, nor are they used by the THAs themselves, as the latter resort to the area reports produced by the HIS.

To summarize, the functionality of the information system for CS IX monitoring activities has been evaluated on the basis of four components:

Data gathering (inputs to the HIS)

Demographic information for the target population was defined in a baseline study conducted during the pre-implementation phase of the CS IX. No subsequent updates have been made to this information.

Epidemiological information related to conditions existing within the household environment is recorded once. at the outset, with the opening of a new family card.

Information on CS IX activities related to the home visit are recorded by the CHW almost in its entirety on the family card. The total number of visits made to a family during its tenure as a CS IX beneficiary family is not recorded; it is possible only to ascertain the dates of visits on which counseling is provided to mothers.

No training activities have been conducted at the level of the THAs, CHWs or leaders of neighborhood organizations in the areas of processing of epidemiological data and monitoring and evaluation. A representative of the THAs and the Health Coordinator participated in the workshops held to discuss the proposal of a single system for information on child survival activities organized by CONASUMI.

The CHWs and THAs have available all of the inputs necessary for recording and reporting data, with the exception of detailed maps showing the locations of households, for the intervention areas, broken down for each individual CHW. There does nor appear to be a need for computers or staff for managing this data at the level of the central office.

Theoretically, there is an established system for discussion of the information and subsequent decision-making. In practice, however, this system provides little opportunity for decentralized participation at the level of the CHWs, much less at the community level.

Data processing (processes)

Calculation of programming goals at the level of the CS IX project areas has been determined in a baseline study. There are no programming goals at the level of the operational supervision areas.

This is also true as well with regard to the target population to be covered.

The information system does not provide for the preparation of instruments to record compliance with goals, at any level. The HIS produces monthly reports that generate descriptive statistics, which makes it impossible to conduct an analysis of trends with regard to attainment of goals and use of services. There are no programming goals by operational supervision areas.

The consolidated reports covering activities carried out by the CHWs during their home visits and the lists of at-risk individuals are received by the HIS operators at the central office level and then delivered to the THAs. The timeliness of these lists is limited. as delays occur in inputting data from the card, which in turn lead to delays in the production of reports.

Calculation of rates and other indicators is adequate, although it is limited to the population served during the preceding month.

No tally is made of home visits.

Data internretation (processes)

Calculation of coverage achieved by component and by area is done only cross-sectionally for the month of the report in question. The HIS does not provide analytical reports on progress made toward achieving coverage either longitudinally or by components, nor by area. Likewise, it produces no data on supervision or resource allocation.

The HIS does not allow comparisons to be made against rates recorded for prior periods.

Use of data for decision-making (HIS outputs)

It is possible to establish, at the management level: progress attained toward compliance with goals for a particular implementation period of the CS IX, broken down by program component. This information is not produced automatically by the HIS, but can be calculated relatively quickly.

It is not possible to assess compliance with goals by operational areas of supervision (neighborhoods).

There are few graphic recording forms available to the CHWs to facilitate decision-making with regard to actions to be taken (for example. the growth and development curve).

The family card is an excellent data recording instrument that facilitates decision-making by the CHW with regard to the type of follow-up required for individual cases. It is not, in and of itself, sufficient to permit situational analysis of the groups of families with which they work, much less transfer knowledge regarding the effect of their actions. Graphic management of data (maps that would identify problems by component or by type of population) would facilitate the decision-making process at the community level.

The monthly CHW reports fulfill no function with regard to the decision-making process at this level. Rather, they respond to the needs for data inputting and processing as established in the operational design of the HIS. They require the use of time that could be used more profitably for other tasks.

Risk criteria are used only to identify those individuals at greatest risk. within the needy population. These individuals will require increased attention from the CHWs. It is not possible to stratify groups of beneficiary individuals in accordance with the severity of their problems (level of risk), particularly when such problems are linked to health-related attitudes and practices.

The analysis and collective discussion of information takes place in monthly meetings of THAs and CHWs. During these meetings, the monthly. CHW reports are analyzed, inconsistencies between the cards and the reports are identified, and the CHWs are trained or brought up to date in areas in which they are weak.

Almost 95% of the information produced by the program is quantitative. originating in data taken from a numerical scale or from categories recorded on the family cards.

This evaluation did not detect the use of qualitative data-gathering techniques as part of the data recording and collection system. The team did verify the use of the techniques of focus groups and in-depth interviews for opinion analysis in conjunction with the annual internal program evaluation.

Generally speaking, no unnecessary data are collected, but consolidated reports that are not necessary for decision-making purposes are prepared manually.

The CS IX makes limited use of the HIS for monitoring purposes. The constraints involved can be described as a function of three aspects of monitoring:

1) A health information system (HIS) must produce basic data (criteria) with which to judge the productivity of the CS IX and allow changes to be made to the way in which activities are conducted on a daily basis.

2) The second refers to the size of the needy population benefiting from CS IX interventions.

3) The third involves monitoring the extent of compliance with CS IX implementation specifications as regards service delivery (home visits).

With regard to the first constraint, the CS IX used the information produced by a census conducted in August 1993 (prior to the implementation stage). That census recorded the number of families with mothers and children under age two residing in the area of influence of the CS IX (a total of 4,500 families included in the census). Although this information has not been updated using the same procedure, the HIS does generate updated data.

That said, an increase has been observed in population size, with a total of 4,938 families now being reported. Thus, it would appear that the tasks performed by the CHWs and THAs as a function of the CS IX intervention need to be reviewed and revised accordingly. The most advisable course of action would probably be to reduce the number of families per CHW (i.e., increase the number of CHWs). Productivity data of this type are not routinely or systematically produced by the HIS.

The second constraint refers to the problem of family migration. Project personnel at the various levels of the CS IX have frequently commented on the high rate of migration of the families residing in the areas of influence of the project. Unfortunately, the THAs and coordinators have been unable to establish, using objectively verifiable means, the exact magnitude and characteristics of this phenomenon. The HIS does not record family mobility, as all family data are eliminated from the system once the family members cease to be CS IX beneficiaries.

Although the beneficiary population, at any given moment, is easy to obtain from the HIS, it is not possible to establish how many needy families and individuals have benefited from CS IX interventions over time (possibly more than 7.000 families).

In the case of the CS IX, the target population consists of individuals rather than families. Accordingly, the responsibility of the CHWs are the mothers with children under age two as well as the children themselves, as opposed to the family unit. It is for this reason that the family card and all individuals included on it disappear from the HIS once the child and/or mother no longer fall within the range of criteria used to define the target population or when they move out of the area.

In the event that a new family member meeting the definitions established for the target population is identified, a new family card is opened and inputted into the HIS, as if no card had ever existed. Thus, a health worker that reports 26 families in her area of operation is not referring to all of the families residing in the geographically defined area in which she works, but rather to those families that have members who meet CS IX eligibility criteria.

The above point is critically important for two reasons: on the one hand, the HIS does not allow an assessment to be made as to whether there exist needy individuals that have not been reached by the CS IX, much less analyze the potential bias associated which such differences.

Contact was made with one health worker who reports 32 families currently under her supervision but who is aware that there are 10 additional families that she has never been able to visit for a number of different reasons. We do not know how many mothers and children in these 10 families have not been reached by the CS IX. Similar situations could exist for at least 10% of the CHWs, particularly in view of the fact that problems have already been reported regarding the reduction in CHW supervision by the THAs.

In addition, the family unit is the smallest social group in the community [and it is here that] intersubjectivity, a sense of belonging and community commitment are reflected. Allowing this family unit to participate in the project even though some of it members do not satisfy the eligibility requirements could be a key factor in developing the community awareness so necessary for the empowerment which, over the longer term, could ensure sustainability.

Lastly, the third constraint refers to compliance with the specifications for intervention delivery. These specifications are not entirely documented in the HIS. For example:

- Although the guidance sessions (talks) provided during the home visits are recorded by content on the family card and fed into the computer, it is not possible to obtain the number of visits made to a given family during its period of participation in the CS IX.

- The number of dates on which counseling was provided that can be recorded by subject matter on the card is limited to five;

- Only the date of the most recent prenatal consultation recorded on the family card is input into the HIS, although all dates are recorded on the family card. We recall that one of the specifications of this intervention is to ensure a minimum of four prenatal consultations for pregnant women.

- A child's history of episodes of diarrhea is recorded on the family card but not processed; accordingly, it is impossible to determine how many episodes of diarrhea occur among children in the project area and how many receive appropriate treatment at home and/or are referred.

The lessons learned can be summarized as follows:

> It is important to establish that the essential element of an information system is processing at the local level, decision-making by the CHWs and feedback to the community. Next in importance is the flow of information to upper management levels.
>
> PLAN should require consolidated information only in order to assess the extent to which the program promotes improvements in coverage and use of services and to decide whether interventions should be expanded.
>
> The health team (THA, Health Coordinator) has an understanding of those aspects of the organization that must be resolved as a result of the introduction of modifications to the HIS. Administrative and supervisory changes should be implemented as soon as possible in order to ensure the effective operation of the system.

4.3 Social Promotion and Community Education. The CS IX has managed to strike a balance between the intensity of promotional and community mobilization activities and those involving the provision of services such as vaccinations, oral rehydration, treatment of pneumonia and administration of vitamin A, folic acid and iron sulphate.

Most of the services have been financed with PLAN budgeted funds. MOH contributions have involved the supply of vaccines and, sporadically. of ORS.

The CS IX has carried out a series of Information, Education and Communication activities in the beneficiary communities, through the home visits made by the CHWs. that make it possible to establish individualized, one-on-one relationships. Group activities are also conducted, especially at the level of the CMCs.

Information and communication are transmitted through printed and video-taped educational materials. Generally speaking, the opinion of both the CHWs and the

mothers is that both educational and formal training activities have been participative in nature. However, KPC data reveal low percentages of vaccination and growth card conservation for both children and mothers (see Annex 1). This means that it will be necessary to step up promotional activities in this area.

No advantage has been taken of periodic meetings held with some of the popular organizations, for which the agenda does not include the topic of maternal-child health, as an opportunity for Information, Education and Communication activities. There has been no initiative, nor has such an initiative been promoted, by which the CHWs would feedback any of the information generated through their activities.

All of the educational material has been the result of a process of field-testing. CONASUMI has currently assumed technical responsibility for the design and testing of much of this educational material. The MOH has also made contributions in coordination with PAHO and UNICEF. PLAN's involvement has been through the organization of focus groups for testing some of the materials.

Some CHW indicated that they had participated in such processes. However, the mothers interviewed had not been given such an opportunity. In the opinion of both CHWs and mothers, the materials are quite useful. Many save them so that they can review them periodically.

Physicians find it useful to have available educational materials that will enable them to provide better quality care. However, during the visits made to seven health facilities. the lack of materials was evident, especially as regards posters containing decision-making flowcharts for diagnosing and treating ARIs. Other promotional materials were also absent. Some health facilities had supplies of certain materials. such as pamphlets and flyers, in storage.

The degree of learning attained by the mothers is verified through home visits made by both CHWs and THAs. One way of measuring this level of learning indirectly is on the basis of the demand for services, as expressed by some physicians.

4.4 Human Resources for Child Survival. The CS IX has in operation a team headed by the Health Coordinator, a physician with a masters degree in public health. who in addition has taken several courses in child survival and has experience as a consultant in this field. The team consists of six THAs, all of whom have university degrees (three in the area of social communication or promotion. one in education. one in nursing, and one in bio-analysis). These individuals have received training and have experience in child survival (they have been working for PLAN for between 1.5 and 6 years).

Based on the above-described characteristics, we can expect that the team will have the ability to implement activities both efficiently and effectively. However, the still existing vertical nature of the project structure has limited management ability at the local level to provide for the full integration of health promotion activities. Integration with the rest of the PLAN area staff (sponsorship programs) has been lacking. This has limited opportunities for strengthening not only the CS IX but also the rest of the programs.

The specific responsibilities of the THAs are summarized below:

- Supervise and follow up on the activities of the comrnuniry health workers (CHW)
- Organize and facilitate CHW training in topics related to child survival interventions; toward this end, basic coordination has been established with the central level of the MOH
- Maintain CHW motivation
- Channel supplies of educational materials to the CHWs
- Conduct educational and promotional activities directly with the beneficiary population
- Provide follow-up to the Caring Mothers Clubs
- Coordinate with local community organizations the implementation of health-related projects

As can be seen, the profile for THAs (as self-defined in the focus groups) includes a lower level of responsibilities vis-a-vis community groups.

The THA is a technically well-qualified resource from the standpoint of CS interventions. but is lacking in management capabilities and group management techniques. This must be taken into account when considering activity sustainability, which in large measure is possible if local organizations are prepared. Such preparation is highly dependent on the technology and skill transfer to be provided by the THA in his or her role as an extension worker responsible for performing a critical social function.

Each THA supervises an average of 26 CHWs, a figure which in the year to date has ranged from a minimum of 24 to a maximum of 28.

At present, 157 PVs are working actively in the CS IX. An attrition rate of 30% has been estimated for the period between January and June 1995. An operational study conducted by the CS IX for the period 1990-1994 concluded that between 9 and 15 CHW leave the program annually, i.e., between 6 and 10% of the total. The average period of service ranges from 9 to 20 months per CHW, with an average of 16. The primary causes of attrition have been identified as inefficiency (30%). leaving to accept a salaried position (19%), and migration out of the area and marriage (14%).

Each CHW is responsible for promoting and providing child survival services to an average of 35 families. The primary method used is the home visit.

The activities conducted by the CHW are summarized below:

- Provide guidance to mothers in the areas of ARI, breastfeeding, birth spacing, diarrhea1 diseases, preparation and use of ORS, and vaccination. CHWs also provide support to the Caring Mothers Clubs.
  Conduct periodic home visits. CHWs are supposed to visit each family an average of twice a month. In 1994, that goal was achieved, but in 1995 to date, the number of visits has averaged 1.33, the principal reason being attributed to the overload of training events that they have been attending during recent months.
- Provide guidance to pregnant women with regard to signs of risk.
- Deliver vitamins and antiparasitic medications and vaccinate children on a house-to-house basis.
- Aid families in looking after their health without spending money.
- Encourage pregnant women to attend their prenatal control consultations.
- In the area of family planning, provide guidance and explain why women should not have so many children.
- Record the various interventions on specially designed cards. CHWs submit a monthly activity report to their THA.

The CHWs receive from PLAN a financial incentive in the amount of RD$100, the equivalent of US$7.49, in addition to tennis shoes, T-shirts and all of the materials and equipment they require to carry out their activities. Most of those interviewed indicated that they would be willing to continue on in their activiries if the financial incentive were eliminated, citing a commitment to their community.

In accordance with the CS IX training program, which is summarized in Table 2, most of the topics addressed in training events have been aimed at CHWs.

The table shows a total of 85 courses covering 25 topics. However, a number of topics have been covered simultaneously during the training sessions. When this is taken into account, the number of courses/topics totals 95. Courses are broken down by intervention as follows: MH/BS, 23; ARI, 16; CDD/ORT, 15; Immunizations, 14; BF. 12; N/GM, 8; and others, 7.

However, if we consider the number of hours per topic/course, distribution by intervention is as follows: MH/BS, 328 hours; ARI, 200 hours; Immunizations, 164 hours; N/GM, 158 hours; CDD/ORT, 144 hours; and BF, 144 hours.

An analysis of the data presented in Table 2 with regard to the exposure of the various types of personnel to training events, taking as the denominator the 25 topics presented.

reveals that the level of exposure has been as follows: CHWs, 88%; THAs, 24%; PDSs (physicians), 8 %; community leaders, 8% ; others, 4% (refers to PLAN field staff, areas supervisors and social promoters carrying out activities related to other programs).

In addition, according to the CS IX Annual Report, THAs have received formal training as follows: refresher courses in CS evaluation methodologies, supervision and management; N/GM; reproductive health; HIV/AIDS; and refresher courses in BF.

The training methodology employed has been of the participative type.

On the basis of this brief analysis, it can be stated that the intervention that has been accorded greatest emphasis is MH/BS and that the category of personnel that has been given the most exposure to training opportunities is the CHW. From the standpoint of intensity (hours/course/topic), distribution by intervention has been uneven, despite the fact that the Annual Report established an equal degree of intensity for each intervention.

The training program implemented to date has placed little emphasis on CHWs, community leaders and other PLAN field staff. Thirty-three percent of the courses have been held during the past four months.

Table 2. Summary of the CS IX IX Training Program, PLAN/USAID Santo Domingo
September 1993 - July 1995

Category of Personnel, Dare. (#)	Training Topic (# of Courses)	Hours per Topic	Training Methods Used for Each Topic
CHW/THA-Sep/93 11/6)	ARI and Maternal Health (8)	16	Presentations, discussiort of cases, videos Roleplay
:H W-Oct/93 (150)	CDD/ORT and Immunizations (6)	16	Presentations, srtpervised practice exercises, videos, roleplay Feedback, supervised practice exercises
CH W-Oct/93 (30)	Immunizations (I)	8	Group discrrssiotu. roleplay, videos, presentation of methods
CHW-Nov/93 (130)	Birth Spacing (6)	16	Feedback to CHWs using videos, group work
CHW-Jan/93 (25)	CDDIORT (I)	8	Videos, roleplay, stipervised practice exercises
PDS-Apr/94 (40)	ARI and CDD/ORT (2)	40	Presentations, videos, roleplay, supervised practice exercises in Robert Reid Cabral Children 's Hospital
CHW-May/94 (131)	Breastfeeding (6)	8	Videos, roleplay, supervised practice exercises
CH W-Jul/94 (29)	Family Planning/AIDS (I)	20	Videos, presentations, group discussions, case discussions, management of family planning methods
Supervisors/THA/PL 4N Social Promoters/Jul/94 (5/6/5)	Primary Care Strategy and Child Survival Inrervenrioris (1)	8	Presentations, group discussions, plenary discrusiotrs
CH W-Aug/94 (29)	Reproductive Health (I)	20	Presentations, group discussions, roleplay
CH W/THA-Aug/94 (30/6)	Nutrition (1)	46	Presentations, srtpervised practice exercises, roleplay, management o f undernourishment

Category of Personnel, Date, (#)	Training Topic (# of Courses)	Hours per Topic	Training Methods Used for Each Topic
'DS-Sep/94 (11)	Family Planning (I)	32	Presentations, supervised practice exercises itr the indications for and use of family planning trrerhods Practice in filling out the card, monthly summary and use of information
:HW/THA-Sep/94 12/6)	Information System (I)	8	Feedback in vaccittariotr techniques
:HW/THA-Oct/94 149/6)	Immunizations (6)	6	Presentations and group discussions
:HW/THA-Nov 20/6)	Community Organization and Parriciparioti (2)	8	Slides, case discussions, supervised practice in adtninisrering vaccitiarions
:HW-Jan/95 (30)	Vaccination Techniques and Immunopreventable Diseases (5)	8	Presentations, slides, group discussions, case discussions
:HW/THA/Leaders-ran/95 (70/6/1 0)	Teamwork and Child Survival (2)	16	Supervised practice exercises, presentations, discussion groups, practical field exercises
:HW/THA - Feb/95 (30/6)	Course on Nutrition and Growth atrd Development Monitoring (1)	16	Supervised practice exercises, presentations, discussion groups, practice field exercises
CHW-Mat-I95 (156)	Course on Nutrition and Growth Monitoring at rhe Community Level (6)	16	Videos, roleplay, supervised practice exercises, group work
CH W-Apr/95 (150)	Diarrhea Case Management attd OR7' (6)	8	Presentations, practice e.wercises. group discussions, individual presentations
ClJ W/THA-Apr/95 (5/6)	Informal Educational Techniques (1)	16	Presentations, supervised practice exercises, filling out [forms] and review of cold chain

Category of Personnel, Date, (#)	Training Topic (# of Courses)	Hours per Topic	Trainittg Merltods Used for Eaclt Topic
CHW/Leaders-Apr/95 (20110)	Vaccination Techniques, Cold Chain (2)	16	Videos, case discussions, groups discussions, plenary sessions, roleplay. supervised practice exercises
CHW-May-Jun/95 (156)	AR1 Case Management (6)	16	Videos, group case discussions, pletraty sessiotts
CHW-Jun/95 (150)	Breastfeedittg (6)	16	Videos, roleplay, supervised practice exercises, group work
CHW-Jul/95 (149)	Birth Spacing (6)	16	Group discussions. roleplay. teaching and counseling in the use of family planning tttethods (advantages attd disadvantages)

4.5 Materials and Supplies for Local Personnel. The basic materials and supplies for health workers in CS IX interventions can be summarized as follows, based on information provided by each of the groups:

> CHW: cards and instruments for recording data, ballpoint pens, CHW handbooks for individual interventions, educational materials for distribution to the target population, scales, packets of ORS, vaccines, thermos bottles, and vitamin and mineral supplements (iron and calcium). They also feel that it is essential that they be supplied with backpacks, tennis shoes and T-shirts.
>
> PDS: vaccines, packets of ORS, educational materials, vitamin and mineral supplements, and antibiotics for management of pneumonia. Some indicated a need to have available ORUs, duly supplied with the appropriate materials and equipment.

CHWs were unanimous in their opinion that they experience no problems regarding the availability of the basic materials and supplies they require to carry out their tasks. The THAs are responsible for keeping the CHWs properly supplied.

With regard to the PDSs, a degree of irregularity exists at the level of the local health facilities regarding the delivery of materials and supplies from the MOH, except with respect to the supply of vaccine.

Two of the seven facilities visited lacked educational and promotional materials, such as posters and pamphlets, for distribution to users. Two of the facilities had supplies of educational materials, but the latter were underutilized, as they were not accessible to either physician or user. In addition, three of the seven health centers (43%) did not have supplies of ORS available at the time of the visit. Fourteen percent (1 out of 7 facilities) did not have available essential drugs for case management of pneumonia on an outpatient basis.

It should be pointed out that PLAN, using its own regular funds. has established mechanisms for drug donations, including drugs essential for curative interventions in the field of child survival. In this regard, it was found that no standardized criteria exist for selecting the drugs used in the health centers operating in the area of influence of the cs IX.

Thus, the physicians in each individual health facility decide which drugs to request from PLAN based on their own personal criteria. This is the main reason why, in addition to flu and cough medications, commercial drugs containing inappropriate combinations, such as dextromethorphan, antihistamine and trimethoprim sulfametoxazole, were found. The drug control and inventory system in the facilities visited is deficient and quite rudimentary. This is an area requiring urgent review.

Drugs are sold at low cost in some health facilities, particularly those operating in locales pertaining to community organizations or local NGOs. MOH health centers provide medications at no cost. Of the seven facilities visited, four (57%) have established cost recovery fees for consultations and drugs.

4.6 Quality. The CS IX, through the efforts of the THAs, provides feedback and current information regularly (at least once a month) to the CHWs. The THAs accompany the CHWs on their home visits to verify the techniques used and observe the way in which the educational message is transmitted, as well as to monitor the preparation of ORS and the administration of vaccines. In the case of a new CHW, the THA is required to provide more intensive monitoring in order to provide the CHW with in-service training and reinforce the theoretical knowledge that she received during the intensive training.

A significant advantage is the optimum level of schooling shown by many of the CHWs. Almost all have completed primary school; in addition, several have secondary level schooling and a number are university students.

The HIS, which is analyzed elsewhere in this report, also contains variables that provide an indication of the degree of knowledge of the mothers. One form of measuring maternal skills is through the CMCs, where supervised practice exercises take place, particularly in the area of BF and MH/BS. However, there are no standardized instruments for assessing the knowledge of CHWs, PDSs and mothers. Indeed, linkages with the PDSs are quite weak in this regard.

During the focus group sessions held with CHWs and mothers, CS topics were evaluated (see the guidelines in Annex 5). These evaluations reflect a high level of knowledge. both among CHWs as well as among the mothers interviewed. A questionnaire containing 10 questions designed to assess physician knowledge was administered to seven physicians in local health facilities (see Annex 5).

The results were as follows: out of a maximum of ten possible points, the average score was 4.3, with a range of between 3 and 6. The greatest errors occurred with regard to the concept of persistent diarrhea (100%); PAHO classification of ARI (57% were unaware of that classification); and diagnosis and management of ARI in infants under age two months (85 %).

4.7 Supervision and Monitoring. The number of CHWs taking part in the CS IX currently stands at 157. Each is responsible for approximately 30 to 35 families. In mm, each THA supervises an average of 26 CHWs (somewhere between a minimum of 24 and a maximum of 28).

Supervisory and training activities for CHWs constitute the primary task of the CS IX. The theoretical impact of the CS IX action model is a function of the quality of the services (interventions) that the CHWs provide through their home visits. The CHWs are able to respond to a number of the demands, whether perceived or unperceived, in terms of health promotion, while channeling more complex demands to area health facilities for diagnosis and early treatment.

The guidelines by which THAs provide supervision to the CHWs attempt to measure, on a scale of one to five (from poor to excellent), the degree of absorption of attitudes and skills by the CHWs. They do not specify the criteria to be used for the overall performance rating, nor a breakdown by component. CHW performance evaluation, based on these guidelines, takes place every three months. However, there are indications that not all CHWs are subjected to this process with the same degree of regularity.

The time required to supervise the CHWs represents the greatest single cost of the CS IX. The various forms that supervision can take (ranging from the formality of supervision based on guidelines using semi-structured questions to comments made to CHWs while observing their daily performance) involve a dynamic that can best be evaluated from a cost-benefit standpoint.

The high rate of attrition of CHWs (30%) makes it necessary to recruit new CHWs and, accordingly, to redouble training and supervisory efforts. The CS IX needs to conduct a more in-depth analysis of the factors that define this process so that alternatives solutions can be identified.

The average number of home visits per CHW per month has dropped from 2 in 1994 to 1.3 for the period from January through June 1995. It is argued that a major portion of the decrease is the result of the high concentration of training activities conducted during the period. Few supervisory activities are performed by the THAs with respect to the CHWs during the home visit. Two THAs have adopted the technique of having CHWs requiring in-service training be accompanied by other CHWs who have been rated as excellent.

With increasing frequency, supervisory activities are being displaced by administrative tasks performed by the THA in the central office. This situation is the result of the vertical nature of the organizational structure of the CS IX.

Reducing the number of administrative tasks would probably lead to a greater availability of time, not only for supervising CHW activities but also for coordinating the activities that the THAs must carry out in connection with community organizations and other local institutions.

Training activities are not consistently recorded.

There is a guide for evaluating the work performed by the THAs, but we have been unable to verify the frequency with which it is used by the CS IX Health Coordinator.

4.8 Regional and Central Office Support. The CS IX received initial support from Dr. Luis Tam, M.D., D.P.H. (Central Office) and Dr. Luis Caris, M.D., Ph.D., in designing the baseline for the CS IX. In addition, technical support has been provided by the ROCCA Health Coordinator, Dr. Gustavo Tapia, M.D., M.Sc., who has visited the CS IX on three occasions since project startup in 1993.

Technical assistance was aimed at supporting the local office in selecting the new Health Coordinator, preparing the Annual Report, organizing the field work, and conducting this mid-term evaluation.

This assistance has identified a need to focus on action lines for transferring to the communities the capabilities that will make sustainability possible. In the opinion of the PLAN/Santo Domingo Health Coordinator, assistance has been both timely and valuable. However, the recommendations have not been implemented, as few changes have been made to the way in which activities are carried out.

4.9 PLAN Use of Technical Support. According to the PLAN/Santo Domingo Health Coordinator, needs for external technical assistance are broken down as follows: strategies for attaining sustainability; Information, Education, and Communication (IEC) strategies; supervision and monitoring; and the information system and its use by management.

To date, the CS IX has benefited from technical assistance provided by CONASUMI, which has partially satisfied needs in the area of information systems and their use by management. The idea is to be able to draw on the above-mentioned technical assistance over the course of the next six months. Toward this end. efforts will be made to formalize agreements with CONASUMI so that the latter can begin to satisfy most of these technical support requirements.

4.10 Evaluation of Counterpart Relationships. Following are the community or neighborhood organizations with which there has been some degree of coordination:

LOS COQUITOS. Fundación de Ciudadanos Conscientes de Hen-era and Los Gigantes. Both are community organizations.

ENRIQUILLO. Coordination with community organizations such as COPROBBEH (Comité Pro-Bienestar de1 Barrio Enriquillo), Junta de Vecinos Padres Comunitarios,

MOINCO (Movimiento de Integración Comunal), Junta de Vecinos Los Pinos, Junta de Vecinos Holguin and the Municipal Health Center.

ALTAGRACIA. NGOs: Fundación Cultural y Educativa de la Salud (FUCES), Proyecto de Desarrollo Integral (PRODECOIN). Government: Clinica Periferica Dr. Diaz Piiieyro, of the MOH.

BUENOS AIRES. Community organizations: Neighborhood Women 's Group. NGOs: Centro de Educación Popular (CEP), Instituto Dominicano de Desarrollo Integral (IDDI). MOH Clinic in Buenos Aires.

LAS PALMAS. Community organizations: Núcleo de Salud Las Abejas, Junta Directiva de1 Centro Comunal de Las Palmas.

LIBERTADOR. Community organizations: Women of Holguin, Grupo de Amas de Casa Unidas. NGOs: Colectivo de Salud Popular National. Government: MOH Clinic.

According to the information provided by the THAs, coordination and collaboration with the above-mentioned organizations has involved the following: exchange of services, facilitation of educational materials, financing, support for training activities, exchange of vaccines, joint activities during vaccination campaign days.

As a rule, it has been PLAN that has provided support in the areas of financing of supplies. Consequently, if we consider the concept of "'counterpart " in its true dimension, the above-listed organizations have not played true counterpart roles, as they have almost never provided resources for carrying out CS IX activities. Some report that several of their members are CHWs, and this is considered to be a contribution. However, these organizations assume no responsibility for the incentives that CHWs currently enjoy.

A good level of coordination has also been achieved with the central level of the MOH, through the availability of technically well-qualified human resources for providing training to local workers engaged in CS activities. The CS IX has also enjoyed assistance provided by IDAN in the training of personnel (THAs and CHWs) in N/GM activities as well as technical support aimed at implementation of the nutritional education centers.

With regard to the extent of the progress achieved by the PLAN proposal entitled "Linkages between Health Providers in the Area of PLAN/Santo Domingo " (see Annex 6), the THAs indicated that things are progressing well at many levels but that there is a need for coordination with health providers.

The Nutritional Education Centers and Oral Rehydration Units have yet to be implemented. In addition, feedback of health information is poor.

The physicians interviewed indicated their lack of awareness of this proposal. They feel that it is reasonable, but that it will be necessary to establish strong mechanisms for ensuring coordination and feedback. There does not currently exist a consistent linkage between health facilities and the CHWs. One of the most important reasons for this is the weak leadership provided by the MOH in the area of influence of the CS IX. An additional constraint is the high turnover of medical personnel, who work only on a part-time basis.

In order to obtain an idea of the supply and demand for these services, a number of variables, including number of physicians, hours worked and number of users, both average and on the day of the visit made to the seven health facilities, were studied. The results are presented in Table 3, below.

Table 3

Health Facility	*Average Users/Day /Week*	*No. of Users Previous Day*	*No. of Physicians*	*No. of Hours Supplied*	*No. of Users/Hour per Physician/Hour**	*No. of Users/Hour per Physician/Hour***
Libertador	*60*	*49*	*5*	*9*	*12*	*9.8*
I' Las Palmas	*6*	*7*	*5*	*7*	*1.2*	*I.4*
Municipal Health Center	*20*	*21*	*2*	*6*	*8.6*	*10.6*
FUCES Center	*10*	*6*	*3*	*7*	*3.3*	*2*
!' Palmar de Herr-era	*1.5*	*14*	*3*	*7*	*4.9*	*4.6*
I Centro de Educaci on Popular Clinic	*17*	*5*	*1*	*4*	*17*	*5*
Dr. Díaz Piñeyro Peripheral Clinic	*100*	*100*	*13*	*8*	*7.7*	*7. 7*

Vote: the medical personnel working in these health centers are paid by the MOH.
** Refers to the average number **of** users **seen** daily every week. To obtain this figure, the number of physicians was weighted in accordance with the hours during which the service was supplied. The same was done **for** the number **of users.***
*** Refers to the number of users seen on the day preceding the visit. This figure is also obtained as explained above.*

The data shown in Table 3 reflect the underutilization of services. This situation should be explored in greater depth, so that PLAN can make available the necessary assistance to enable the MOH and local organizations to analyze this issue. Meanwhile, it is recommended that PLAN discontinue its support for the construction and equipping of other health centers in the CS IX area of influence.

The staff of local counterpart organizations do not presently have the capacity, and particularly the administrative capacity, to eventually assume full responsibility for CS activities.

4.11 Referral Linkages. Annex 6 presents the schematic design of the linkages between health providers.

Health providers consist of five types of organizations:

1) Community organizations
2) Comrnunity health workers
3) Caring Mothers Clubs
4) Community Health Centers. There are six such centers in the project area. In addition, the MOH peripheral clinics operating in the area of influence of the CS IX should also be included.

Geographic accessibility is optimal. The supply of services is quite limited and service quality may be evaluated as a function of the type of therapeutic management that physicians provide for their patients with ARI and diarrhea. According to the survey of health provider knowledge with regard to the management of diarrhea1 diseases and ARIs, such knowledge ranges between fair and poor.

Neither the CHW, the main office or the field staff are jointly using the information produced by the CS IX because they have no access to it, as a result of the lack of coordination within PLAN. Likewise, with the exception of the CHWs, health providers are not forwarding data on services supplied broken down by population segment.

A significant portion of the health providers interviewed are not familiar with the scheme of linkages that in theory exists among health providers working in the project area.

4.12 Existence of an NGO **Network.** As of October 1993, CONASUMI has been operating as an umbrella organization consisting of 14 member NGOs, of which ten implement CS IXs in the Dominican Republic. At present, their funding is provided solely by AID.

The benefits provided by CONASUMI to date can be summarized as follows: greater decision-making capabilities and greater ability to negotiate with government agencies; systematization and standardization of the CS services provided by member NGOs in more than 400 communities; systematization of the training process through the use of the "training by levels " technique; delimitation of the geographic areas covered by each NGO, thus avoiding duplication of efforts and conflicts based on areas of responsibility; and standardization of the design and testing of educational and training materials.

CONASUMI has in place an operating unit staffed by five employees whose duties are divided between technical and administrative functions. The operating costs of the unit are shared equally by AID and member NGOs. CONASUMI considers PLAN to be a Type II NGO, i.e.,one that does not receive financing but is eligible to receive technical assistance.

Member NGOs identified the following weaknesses in CONASUMI: weak internal structure of some member NGOs; CONASUMI depends on funds provided by a single donor (AID); and bureaucratic delays as a result of management problems affecting certain NGOs.

Detailed information on CONASUMI can be found in the Report of the Mid-Term Evaluation recently conducted with regard to this organization.

None of the local NGOs operating in the area of Herrera are currently implementing any specific CS projects. Thus, PLAN is the primary NGO conducting such activities in specific operating areas. Other national NGOs are carrying out intervention activities in areas such as family planning. However, no clearly defined evidence of any duplication of efforts with other nongovernmental organizations was observed.

4.13 Budget Management. Budget implementation for this grant year (through June 30, 1995) stands at about 54%. Between September and December of 1994 it was 4 % ; thus an increase of 50 percentage points was recorded between January and June of 1995. It is the opinion of the PLAN accountant that, based on that level of budget implementation, some 7580% of the budget corresponding to grant year 1995, which ends in August, is expected to be spent.

Causes for the low level of budget implementation include the following: management problems involving the new Health Coordinator, and a degree of confusion among members of the health team regarding a planning process for bringing about the integration of the CS IX with other PLAN programs, which although time-consuming provided no palpable results for the CS IX.

Accordingly, following appropriate advice and pressure brought to bear by management, the health team has reacted with an improvement in the level of budget implementation over the past six months.

The remaining funds appear to be sufficient for a continuation of CS IX activities. If the current trend in budget implementation continues, thus permitting the adoption of a dynamic approach to the target population and reinforcing the activities of the sustainability plan, the funds could be used in their entirety.

The following lines of actions for reversing the current trend in budget implementation and optimizing CS IX implementation have been identified:

1) Coordinate activities with CONASUMI to finance the of testing, design and reproduction of educational materials.

2) Support the MOH in the financing of: a) educational materials testing, design and reproduction, and b) training of medical and nursing personnel, in view of their high rate of turnover in the area of influence of the CS IX.
3) Strengthen local organizations within the area of influence of the CS IX, through empowering processes aimed at facilitating transfer of responsibilities from the CS IX. This would include, in addition, both MOH and PLAN staff.
4) Contract technical advisory assistance in the areas of IEC and various aspects of sustainability.
5) Procure supplies and equipment considered essential for implementation of the various interventions: a) N/GM - scales, furniture and equipment for optimum operation of the three nutritional education centers; b) CDD/ORT - furniture and equipment for the installation of four ORUs; and c) Immunizations - purchase of thermos bottles, thermometers and expendable supplies for strengthening the cold chain. (Equipment purchases will not be made with USAID funds).
6) Increase CS IX coverage by an additional 550 families.
7) Expand interventions to include specific IEC activities aimed at HIV/AIDS prevention, which are necessary given the high of rate of prevalence of this problem in the area of Herrera.

5. Sustainability

Table 4. Goals, Objectives, Steps Taken, Mid-term Adjustments and Steps Required to Attain Sustainability

Goal	End-of-Project Objectives	Steps Taken to Date	Mid-Term Adjustments	Steps Required
Attain a sustainable health status for the maternal and child population	1. 95% of the CHWs will belong to community organizations.	1. Integration of the CHWs into organizations, and/or the possibility that such organizations will provide CHWs, is currently being discussed. 51% (79/156) of CHWs currently belong to community groups. Only the women's group of Barrio Buenos Aires has coordinated its activities with those of the CS IX.	1. Integrate the CS IX into the activities of all organizations.	1.1 Train the organizations in CS IX [activities] and in identifying the need for the project. 1.2 Provide feedback of HIS information to the organizations.
	2. 60% of CS IX technical and administrative activities will be conducted by community groups, local NGOs and the MOH.	2. A process aimed at increasing the awareness of the organizations regarding the responsibilities that they will assume and identification of the need for organizational strengthening has begun. None of the activities are conducted in their entirety by the organizations.	2. Training and transfer of administrative responsibilities and strengthening of services. Implement the flowchart of horizontal linkages between health providers in the area of influence of the CS IX.	2.1 Carry out a process of technical and administrative transfer through training activities and planning workshops. 2.2 Formalize coordination mechanisms with the organizations and with the MOH.
	3. 70% of mothers with children under age 2 will be able to transmit CS IX messages to other mothers.	3. CHW training is being improved so that educational messages transmitted to mothers will be more effective and ways to reinforce the information and knowledge transmitted are being identified. A course on informal education techniques was given. In addition, 44 CMCs have been organized.	3. Strengthen the Information, Education and Communication strategy while simultaneously strengthening the ability of the CHWs to transmit their knowledge.	3.1 Specialized technical advisory assistance in the area of IEC. 3.2 Strengthening of the structure of the CMCs by involving the CHWs in activities coordination.

Goal	End-of-Project Objectives	Steps Taken to Date	Mid-Term Adjustments	Steps Required
	!. The project will itnprove 'anagement systems supplies, maintenance, 'ransportation, communication, Health Information System, 'thers) in 60% of NGOs, MOH 'ealth facilities and neighborhood organizarions troviditg health services al rhe ocal level.	Existing deficiencies have been identified and efforts to ensure 'rdination with 2 NGOs ONASUMI and Instituto de Educaci ón Popular) aimed ar 'uring technical assisrance have been initiated.	1.1 Provide training in health care 'anagement for communities 'roups, NGOs, and rhe MOH (Local 'nd Regional Levels). 1.2 Coordinate the integration of the HIS inro the MOH. 1.3 Facilitate the study of the administrative systems of local 'ealth facilities based on crireria of 'fficiency and effectiveness.	1. I Hold workshops for local 'rganizations, NGOs and rhe MOH on topics involving management and information 'ystems. 1.2 Integrate the HIS into rhe 'ocal health facilities of rhe UOH, NGOs and community 'rganizations. 1.3 Strengthen local CS analytical capability.
	i. The functional integration 'f CS IX activities will be 'nitiated with 60% of NGOs, MOH health facilities and neighborhood organizarions. ?O% of private sector 'hysicians in the area of rhe 'roject will be involved.	Integration with three 'ganizations (Centro Educaci ón 'pular de Buenos Aires, Padres 'munitarios de Enriquillo, y JCES) has taken place. There s not yer been any involvement private sector physicians.	5. I Jointly with rhe MOH, rhe Dominican Medical Associarion and 'he Association of Private Clinics, 'he joint activities required to involve 'he private tnedical sector in CS 'ctivities will be identified. 5.2 Facilitate rhe implementation of 'coordination and linkages between 'local level orgatiizariotrs.	5 . Coordinating meetings. Training activities. Alternative forms of service. Establishment of coordination mechanisms and cooperative agreettietits.
	5. 20% of project expenses will be covered through community contributions and rhe remaining 80% will be covered by the MON and other NGOs.	No steps have yet been taken.	5 . I Identify alternatives forms of contributions from the community as well as from NGOs and the MOH. 6.2 Review cost recovery systems in clinics operated by local orgatrizariotis	6 . 1 Conduct workshop-type ttieetitrgs with local organizations, including rhe MOH. 6.2 Technical advisory services in sustainability strategies. 6.3 Provide training to rhe organizations in financial management and self-generation of funds (cooperatives, communities, ttredical insurance).

6. RECOMMENDATIONS

Strengthen the organizational structure of the CMCs, as a genuine community group with the ability to promote, on a sustainable basis, educational and promotional activities among peers. Toward this end it will be necessary, through joint consultation with the groups, to reflect and make appropriate decisions regarding: coordination (should be assumed by the mother) and expansion of coverage (not only to pregnant women and breastfeeding mothers but also to mothers with children under age 2 years).

Information is a significant strategic element for initiating the transfer of technical power from PLAN to the community. A more participative process for analyzing information (by the community) needs to be promoted. The capacity for analyzing information for decision-making purposes through graphically-based procedures and presentation formats needs to be developed.

Since there has been an underutilization of budgeted funds, coupled with a static approach to the number of project beneficiaries, it is recommended that a dynamic approach be adopted that would make it possible to capture a greater target population, to the extent allowed by the budget. At the same time, lines of action (see section 4.13) should stress the transfer of capabilities to local organizations having a high degree of credibility, so that they in turn can contribute to the sustainability of CS IX activities. Given the high prevalence of HIV/AIDS in the area and the low degree of knowledge among mothers regarding mechanisms of transmission and prevention (see Annex 1), there exists a rationale for initiating IEC activities among the general public.

It will be necessary to define credibility criteria for local organizations based, among other factors, on their legal status, community representativeness, prior demonstrated experience, and organizational structure. At the same time, pilot tests designed to permit close monitoring of the processes involved, and appropriate adjustments or corrections as necessary, should be implemented.

It is important that the technical assistance provided by the regional office emphasize and support the lines of action to be followed. Toward this end, there will be a need for a monitoring process that will enable the regional level to make timely suggestions aimed at making changes or adjustments to operating strategies.

CS IX activities will be more relevant if community structures such as the CMCs are strengthened; if support is provided for information exchange and analysis among the various local health providers; if the CHWs are empowered to discuss and analyze correctly information they collect from family' groups and not only from individuals; and if promotional activities are increased through all available media (but especially through one-on-one encounters).

The personnel in charge are very qualified and have specific knowledge of CS interventions. However, the profile for these individuals needs to be reevaluated so that they can be provided with management skills in information use and the transfer of such skills to local organizations. The administrative work-load of the field personnel needs to be reviewed, so that there will be an appropriate balance between such activities and the essential activities of these individuals as facilitators of community participation processes.

The quality of the services provided by the CS IX can be improved if the workload of the CHWs is reviewed (especially as regards the amount of data gathered and the reports to be prepared); if technical coordination between health facilities and CHWs is encouraged and facilitated; if criteria for selecting, programming and managing materials and supplies (including drugs) are revised; and if health facility personnel are trained through the implementation and strengthening of a strategy of continuing training through medical associations, the MOH and other similar institutions (this can include mechanisms such as self-instruction modules, long-distance training and other viable options).

The lessons learned by the CS IX can be given broad-based dissemination, through CONASUMI, to other NGOs operating in the country; however, other PLAN offices with CS IXs could also benefit from the experiences if the regional offices were to facilitate data exchange through regularly scheduled training programs.

7. SUMMARY

Measurable inputs and outputs for individual interventions that have been recorded to date point to an acceptable level of implementation as compared to the expectations established in the DIP. A high rate of compliance can be observed with regard to human resource training, particularly CHWs and THAs. Using its own regular funds, PLAN has provided drugs such as antibiotics, vitamins (vitamin A, folic acid) and minerals (iron and calcium), as well as ORS.

However, certain outputs for which implementation should already have begun have not yet been achieved (for example, only 7 of 15 permanent vaccination posts are currently functioning; none of the 4 ORUs has yet been installed; and 2 of the 3 CENs have yet to be installed).

Forty-four Caring Mothers Clubs (CMCs), which have become self-help groups providing counseling and training in BF and MH/BS, have been organized. The CMCs have a weak organizational structure, since there has been no one to act as coordinator for the mothers. The continuity of the CMCs has been dependent on the motivation of the CHWs and THAs.

The CI-IW home visit is the operational tactic chosen by the CS IX for delivering education and promotion to mothers regarding the benefits of the project. According to some of the CHWs and mothers interviewed, CS IX credibility is high, as a result of which many mothers have decided to follow the advice provided by the CHWs, despite the fact that some physicians, especially those working in the private sector, contradict CS norms by providing conflicting indications.

The educational materials have resulted from a process of testing. CONASUMI has assumed technical responsibility for the design and testing of much of the educational materials. It is the opinion of the CHWs and mothers that the materials are very useful. During the visit made to seven health facilities, the lack of such materials, especially posters, was evident.

Human resources used for CS activities consist primarily of the THAs and CHWs. 157 active CHWs are currently working for the CS IX. A significant advantage is the high level of schooling of a large number of the CHWs, although this could also be contributing, along with other possible causes, to a high dropout rate (30% in 1995).

The vertical nature of the current project structure has limited management ability at the local level to institute integration with health providers. Likewise, there has been little integration with the rest of the personnel working in the area of influence of PLAN

(sponsorship programs). This has limited the extent to which it has been possible to strengthen the CS IX and other PLAN programs.

With regard to training, the CS IX has provided 85 courses, covering a total of 25 topics. Since some courses have covered more than one topic, the total is actually 95 courses/topics. The intervention receiving the greatest emphasis is MH/BS, while CHWs represent the category of health personnel receiving the greatest exposure to the training provided.

The training program implemented to date has placed little emphasis on PDSs, community leaders and other PLAN field personnel. 33% of the courses have been conducted over the past four months, which has led to an overload of training activities with a subsequent decrease in project activities (the average number of CHW home visits/family/month has recently dropped from 2 to 1.3).

CHWs are being supplied on a timely basis with adequate amounts of the basic materials and supplies they require to carry out their tasks. At the level of the local health facilities, some irregularity has been observed in the delivery of supplies and materials from the MOH, except as regards the supply of vaccines. Several of the facilities visited lacked educational materials, ORS and essential drugs for managing pneumonia on an outpatient basis.

PLAN has established mechanisms for the donation of drugs, including those considered essential for curative interventions in the field of CS. There are no consistently applied criteria for selecting the drugs to be used in the health facilities operating in the area of influence of the CS IX. The system for drug control and inventory in the centers visited is deficient and very rudimentary. This is an issue that demands urgent review.

A questionnaire designed to measure knowledge was administered to seven health facility physicians. The results point to a need to make available current information to health personnel with regard to a number of CS interventions. The greatest errors were observed with regard to: the concept of persistent diarrhea (100%); PAHO classification of ARI (57% were unaware of that classification); and diagnosis and management of ARI in infants under age two months (85 %).

With regard to counterpart relationships, the CS IX has attempted to conduct joint activities by enlisting the involvement of local organizations. PLAN has supported the construction of some of these organizations and/or their fitting out with furniture and/or materials and supplies. Some are staffed by medical personnel paid by the MOH.

In response to the recommendations formulated by the DIP Review Committee, PLAN designed a flowchart showing the linkages between health providers in the area of influence of the CS IX (see the graphic in Annex 6). In the opinion of health providers

(sponsorship programs). This has limited the extent to which it has been possible to strengthen the CS IX and other PLAN programs.

With regard to training, the CS IX has provided 85 courses, covering a total of 25 topics. Since some courses have covered more than one topic, the total is actually 95 courses/topics. The intervention receiving the greatest emphasis is MH/BS, while CHWs represent the category of health personnel receiving the greatest exposure to the training provided.

The training program implemented to date has placed little emphasis on PDSs, community leaders and other PLAN field personnel. 33% of the courses have been conducted over the past four months, which has led to an overload of training activities with a subsequent decrease in project activities (the average number of CHW home visits/family/month has recently dropped from 2 to 1.3).

CHWs are being supplied on a timely basis with adequate amounts of the basic materials and supplies they require to carry out their tasks. At the level of the local health facilities, some irregularity has been observed in the delivery of supplies and materials from the MOH, except as regards the supply of vaccines. Several of the facilities visited lacked educational materials, ORS and essential drugs for managing pneumonia on an outpatient basis.

PLAN has established mechanisms for the donation of drugs, including those considered essential for curative interventions in the field of CS. There are no consistently applied criteria for selecting the drugs to be used in the health facilities operating in the area of influence of the CS IX. The system for drug control and inventory in the centers visited is deficient and very rudimentary. This is an issue that demands urgent review.

A questionnaire designed to measure knowledge was administered to seven health facility physicians. The results point to a need to make available current information to health personnel with regard to a number of CS interventions. The greatest errors were observed with regard to: the concept of persistent diarrhea (100%); PAHO classification of ARI (57% were unaware of that classification); and diagnosis and management of ARI in infants under age two months (85%).

With regard to counterpart relationships, the CS IX has attempted to conduct joint activities by enlisting the involvement of local organizations. PLAN has supported the construction of some of these organizations and/or their fitting out with furniture and/or materials and supplies. Some are staffed by medical personnel paid by the MOH.

In response to the recommendations formulated by the DIP Review Committee, PLAN designed a flowchart showing the linkages between health providers in the area of influence of the CS IX (see the graphic in Annex 6). In the opinion of health providers

(CHWs and health facility-based physicians), there has been little progress in this area, for the following reasons:

CHWs continue to have a direct relationship with PLAN THAs. No systematic linkage currently exists between health facilities and the CHWs.

Poor feedback of health information. The information generated by the CHWs is not made known to, much less analyzed by, the local level. There have been no initiatives aimed at instituting feedback of health information by CHWs, nor have any such initiatives been encouraged.

The Caring Mothers Clubs continue to be hampered by their weak structure.

No advantage has been taken of the regular meetings held by some of the popular organizations, the agenda for which does not include the topic of maternal-child health, as an opportunity for education, information and communication.

MOH leadership at the local level is very weak.

The lack of stability of medical personnel in MOH health facilities. One obstacle is the high turnover of medical personnel, who work only on a part-time basis.

Some 50% of the CHWs do not belong to local organizations.

The CS IX has maintained a vertical structure, which is in turn reinforced by a health team that is dependent on PLAN.

The existence of two parallel PLAN structures working in the communities - the sponsorship program structure and the health program structure - which have not yet been integrated at the local level.

Failure to implement the CENs and ORUs.

PLAN should require consolidated information only for purposes of estimating the extent to which the CS IX promotes improvement in service coverage and use and deciding whether specific interventions should be expanded.

The CS IX has attempted to maintain a balance between the intensity of community promotion and mobilization activities and activities involving service delivery. Most of the supplies and materials required by the health facilities have been provided by PLAN with its own funds. MOH support consists primarily of the supply of vaccines.

The evaluation detected an underutilization of the health facilities operating in the project area. This situation needs to be reviewed in greater depth, toward which end PLAN might consider making available the necessary assistance to enable the MOH and local organizations to properly analyze this issue. Meanwhile, it is advisable for PLAN to discontinue its support for the construction and equipping of additional health centers in the area of influence of the CS IX.

Budget implementation for this fiscal year (through June 30, 1995) stands at a level of approximately 54%. Between September and December 1994, this figure was only 4%, meaning that an increase of 50 percentage points occurred between January and June 1995.

The staff of the local counterpart organizations do not currently have the capacity, and particularly the administrative capacity, to eventually assume full responsibility for CS activities.

The proposed sustainability plan involves a high degree of commitment to local organizations.

There is a need to refocus the function of the THA as a social facilitator of processes for transferring technologies and skills to local organizations, as well as for identifying strategies for decentralizing responsibilities to local counterparts equipped with a high degree of institutional and community credibility.

PVO/COUNTRY: Plan International USA/Dominican Republic (Santo Domingo)
Cooperative Agreement No. FAO-0500-A-00-302 I-00

Date Submitted to USAID: October, 1995

1995 PIPELINE ANALYSIS: PART B - COUNTRY BUDGET

		EXPENDITURES TO DATE (09/01/93 - 08/3)5)			PROJECTED EXPENDITURES (09/01/95 - 08/31/96)			TOTAL AGREEMENT BUDGET (09/01/93 - 08/31/96)		
I. DIRECT COSTS		USAID	PVO	TOTAL	USAID	PVO	TOTAL	USAID	PVO	TOTAL
A. PERSONNEL	1. Headquarters - n/a									
	2. Field, Technical Personnel - wages/salaries			0	0	0	0	0	0	0
	3. Field, Other Personnel - wages/salaries			0	0	0	0	0	0	0
	4. Fringes - Headquarters & Field			0	0	0	0	0	0	0
	SUBTOTAL - PERSONNEL	0	0	0	0	0	0	0	0	0
B. TRAVEL/PER DIEM	1 Headquarters - Domestic (USA) - n/a									
	2 Headquarters - International - n/a									
	3 Field - In country	29,194		29,194	0,006	0	0,006	30,000	0	38.000
	4 Field - International			0	0	0	0	0	0	0
	SUBTOTAL - TRAVEL/PER DIEM	29,194	0	29,194	0,006	0	0,006	3 0 , 0 0 0	0	38.000
C. CONSULTANCIES	1 Evaluation Consultants - Fees	9,808		9,008	11,692	0	11,692	21,500	0	21,500
	2 Other Consultants - Fees	5,026		5,026	25,974	0	25,974	3 1,000	0	31,000
	3 Consultant travel/per diem	18,556		18,556	(3,231:)	0	(3,231)	1 5 , 3 2 5	0	15,325
	SUBTOTAL - CONSULTANCIES	33,390	0	33,390	34,435	0	34,435	67,825	0	67,025
D. PROCUREMENT	1. Supplies									
	a. Headquarters - n/a									
	b. Field Pharmaceuticals			0	0	0	0	0	0	0
	c. Field - Other	64,695		64,695	53,570	0	53.570	110,265	0	116,265
	2. Equipment									
	a. Headquarters - n/a									
	b. Field			0	0	0	0	0	0	0
	3. Training									
	a. Headctuarters - n/a									
	b. Field			a	0	0	0	0	0	a
	SUBTOTAL - PROCUREMENT	64,695	0	64,695	53,570	0	5 3 , 5 7 0	118,265	0	118,265
E. OTHER DIRECT COSTS	1 Communications									
	a. Headquarters - n/a									
	b. Field	149		149	(149)	0	(149)	0	0	0
	2. Facilities									
	a. Headquarters - nla									
	b. Field			0	0	0	0	0	0	0
	3. Other									
	a. Headquarters - nla									
	b. Field	5,081	86,406	91.407	15,919	(4,708)	11,211	21,000	81,698	102,69
	SUBTOTAL - OTHER DIRECT	5,230	86,406	91,636	15,770	(4,708)	11,062	21,000	81,698	102,698
TOTAL - DIRECT COSTS		132,509	86,406	210.91 E	112,581	(4,708)	107.072	245,090	81,698	326,788
II. INDIRECT COSTS	1. Headquarters - n/a									
	2. Field	23,189	15,121	38,310	18,721	(1,152)	17,569	41,910	13,969	55,879
TOTAL - INDIRECT COSTS		23,189	15,121	38,310	18,721	(1,152)	17,569	41,910	13,969	55,879
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		155,698	101,527	257,225	131,302	(5,860)	125,442	287,000	95,667	382,667

TOTAL PROJECT

v. ANNEXES

Annex I

KPC Survey

(Bound Seperately)

ANNEX2

CS IX IX Mid-Term Evaluation Plan
July 1995

Activities	Date	Support	Individuals Responsible
Meeting with PLAN staff Meeting with local consultant	10		Dr. Soto Dr. Fernández
Accumulation and review of documents and bibliography Introductory meeting and adjustments to the evaluation plan	11	Supply of documents	Evaluation team
Preparation of guidelines/visit to Herrera	12	Logistics	Dr. Soto Dr. Fernández
Focus group with THAs (a.m.) Focus group with CHWs (p.m.)	13	Cassette recorder, batteries, rapporteur, refreshments, secretarial support	Dr. Soto Dr. Fernández Lic. Miranda
Interviews with community leaders	14 and 15	Logistics and introductions	Dr. Soto Dr. Fernández THA
Focus groups with providers MOH, NGOs (a.m.) CONASUMI (p.m.)	17	Cassette recorder, batteries, rapporteur, refreshments, secretarial support	Dr. Soto Dr. Fernández Lic. Miranda
Visits to health facilities	18	Logistics and introductions	Dr. Soto Dr. Fernández THA
Interview with MOH maternal-child health managers (a.m.) Focus groups with Caring Mothers	19	Logistics and introductions Cassette recorder, batteries, rapporteur, refreshments, secretarial support	Dr. Soto Dr. Fernández THA Lic. Miranda
Interview with MOH maternal-child health managers (a.m.)	20	Logistics and introductions	Dr. Soto Dr. Fernández THA
Data processing and analysis Delivery of preliminary report by local consultant (Dr. E. Gómez)	21 and 22	Logistics	Dr. Soto
Preliminary discussion of results Preparation of presentation	24	Materials for visual aids, refreshments	Evaluation team
Presentation to the director and staff a.m.) Presentation to NGOs, communities, and MOH (p.m.)	25	Logistics, locale, refreshments	Evaluation team

Preparation of final report and incorporation of the results of the survey and of the information system evaluation	26 and 27	Logistics	Evaluation team
Editing, review and submission of final report	28		Evaluation team

ANNEX 4

List of Individuals Contacted

PLAN/Santo Domingo

Mr. Rezene Tesfamarian, National Director
Dr. Francisco Fernández, Health Coordinator
Mrs. Margarita Rosa, Supervisor for the El Libertador/Altagracia area
Enf. Violeta Novas, THA Los Coquitos
Lit. Ercilia Azcona, THA Enriquillo
Lit. Rafael Miranda, THA Altagracia
Lit. Gladys Esttvez, THA Buenos Aires
Lit. Daysi Rosado, THA El Libertador
Lit. Adonis Carrasco, Accountant

MOH

Central Level
Dr. Sonia Maria Aquino, National Reproductive Health Coordinator
Dr. Adalberto Rodriguez, in charge of the EPI Cold Chain
Dr. Mildred Acosta, National Coordinator of the ARI Control Program
Dr. Hilda Cruz, in charge of Community Level Educational Program

Local Level
Dr. Juan Ramos, General Physician, Dr. Diaz Piñeyro Peripheral Clinic
Dr. Abdia Feliz, General Physician, El Palmar Community Clinic
Dr. Danilo Durán, General Physician, FUCES Clinic
Dr. Rafael Herrera, General Physician, Las Palmas Medical Center

CONASUMI

Dr. Angel L. Alvarez, Executive Director
Dr. Johnny Rivas, General Supervisor
Lit. Leonidas De La Cruz, Representative of the Fundacion para el Desarrollo de la Juventud (FUDEJOVEN)
Lit. Magdalena Jiménez, Representative of the Fundacion para Desarrollo Comunitario (FUDECO)
Lit. Dorcas de Amparo, Representative of the Asociación Agua Viva (AAVI)
Lit. Carmen Buret, Representative of Acción Evangelica de Desarrollo (AED)
Lit. Rosa Rosario, Representative of Servicio Social de Iglesias Dominicanas (SSID)
Lit. Carmen Graveley, Representative of World Vision

COMMUNITY

Community Organizations and Local NGOs

Ramón Peiia, Coordinator (1.5 years), Comite Pro-Bienestar del Barrio Enriquillo de Herr-era (COPROBBEH)
Estevama Jiménez, President (1 year), Proyecto de Desarrollo Comunitario Integral (PRODECOIN)
Miguelina Peiia, Secretary (1 year), PRODECOIN
Miledis Morel, Secretary (1 year), Maria T. Sanchez Women's Group
Bernardo Medina, Treasurer (3 years), Centro Educación Popular (CEP)
Pablo Santana, President (4 years), Club 16 de Agosto
Luz de1 Carmen, Women's Group of Barrio Buenos Aires
Ingrid Vásquez, Women's Group of Barrio Buenos Aires
Flavia Liriano, Secretary (1 year), Junta de Vecinos Padres Comunitarios
Odalis Thomas, President (2 years), Asociacion Club Nuevo Ambiente
Oscar Gonzalez, Secretary (2 years), Asociacion Club Nuevo Ambiente
Ruben D. Burdiez, Member at Large (2 years), Asociacion Club Nuevo Ambiente

CHW

Natacha Hemandez (1 year), Barrio Altagracia
Ana Maria Suarez (7 months), Barrio Enriquillo
Brasilia Rosario (3 years), Barrio Enriquillo
Eliza Mota (5 months), Barrio Las Palmas
Gricelda Alonzo (2 years), Barrio Las Palmas
Flavia Núñez (4 years), Barrio Buenos Aires
Martha Jimenez (1 month), Barrio Buenos Aires
Altagracia Figueroa (5 years), Barrio El Libertador

CMC

Sonia Diaz (1 year), Barrio El Abanico de Herrera
Carmen Julia (10 months), Barrio El Abanico de Hen-era
María Rafaela (1 year), Barrio Duarte
Orquidea Rodriguez (2.5 years), Barrio Buenos Aires
Dulce Maria (3 months), Barrio Buenos Aires

Note: the number in parenthesis refers to time in current position.

ANNEX 5
DATA GATHERING INSTRUMENTS

SUBJECT GUIDE FOR FOCUS GROUP

TECHNICAL HEALTH ASSISTANTS (THA)

Date:_____ Time Started:_____ Time Finished:_____

Place : _____

Number of Participants: Men:__ Women:-

NAME OCCUPATION LENGTH OF SERVICE COMMUNITY

NUMBER OF ACTIVE COMMUNITY HEALTH WORKERS (CHW):

COMMUNITY	1993	1994	1995

PROFILE, FACILITATING FACTORS, CONSTRAINTS

1) What is the occupational profile of the THAs?

2) What facilitating elements can be used to develop that profile?

3) What constraints will affect development of that profile?

4) What should the role played by the THAs be?

5) What relationship exists between the THAs and the rest of PLAN field personnel?

6) What is the role or function of CHWs and other community volunteers in the CS IX?

7) What incentives could be used to strengthen the participation of the CHWs?

8) What role do THAs play in health facilities (MOH, NGO)? Why?

9) What relationship exists between the THAs and the PLAN Health Coordinator? What should that relationship be?

SOCIAL PROMOTION AND COMMUNITY EDUCATION

10) What IEC activities has the program conducted?

11) How has the process of testing and producing educational materials been carried out? Are these materials simple and useful?

12) How are these materials valued by the health providers, CHWs and community?

13) How are educational activities carried out? Are they participative or traditional in nature?

14) How are these materials and techniques used to evaluate the level of community learning?

15) What has the CS IX done to encourage family participation and to ensure increased family benefits from CS IX services and activities?

SUPPLIES AND MATERIALS FOR LOCAL PERSONNEL

16) What materials and supplies are considered essential for THAs, CHWs, direct health providers, broken down by CS intervention?

17) Have these materials been made available to the above-mentioned personnel on timely basis? In appropriate amounts? Why?

QUALITY

18) How has the CS IX identified the needs of mothers, CHWs and health providers for the training, knowledge and skills or abilities they require to properly carry out CS interventions?

19) How have the knowledge and skills of mothers, CHWs and health providers been evaluated?

EVALUATION OF COORDINATION WITH COUNTERPARTS

20) List, by community, all counterpart organizations with which activities have been coordinated.

21) What cooperative activities have been carried out? Exchange of materials, personnel, financing, training, etc.

22) What has been the extent of the progress achieved in the "Linkages between Health Providers in the Area of PLAN/Santo Domingo" proposal? Show graphic.

23) Do the staff of these organizations have the technical and administrative abilities to assume responsibility for CS IX activities?

Identify the vaccination scheme that should be applied to a child (which vaccines and at what ages)

10) NUTRITION AND BF

What type of nourishment should a pregnant women receive, in terms of amount and quality

What nourishment should the child receive during his first year of life (first 4 to 6 months, exclusive BF; thereafter, complementary nourishment in addition to BF)

SOCIAL PROMOTION AND COMMUNITY EDUCATION

1) What educational activities have been conducted in the area of CS?

12) How has the educational materials testing and production process been carried out? Are these materials both simple and useful?

13) What value do you and the people in your communities assign to these materials?

14) How are educational activities carried out? Are they participative or traditional in nature?

15) How is the level of learning of the people of your community evaluated with regard to these materials and techniques?

16) What has the CS IX done to encourage family participation and to ensure that families receive increased benefits from CS IX services and activities?

17) What linkages exist between yourselves and the health facilities operated by the MOH and other organizations sponsoring health projects in your community?

18) Do you consider yourselves to be PLAN CHWs or health volunteers in your community?

SUPPLIES AND MATERIALS FOR LOCAL PERSONNEL

19) What materials and supplies are considered essential for CHWs, broken down by CS intervention?

20) Have these materials been supplied to you in a timely fashion? In appropriate amounts? Why?

21) What incentives would you like to have to motivate you to continue your work as CHWs in your community?

GUIDELINES FOR INTERVIEWS WITH KEY COMMUNITY INFORMANTS

Date.___/___/__ Place:_____

Locale :_____ Time Started:- Time Finished*:___

Name of Interviewee:_____

Position:_____ Length of Service:_____

Organization: _____

Occupation/Profession: _____

1) What activities does your organization carry out?

2) What are the principle problems existing in your community?

3) What community development projects have been conducted with PLAN?

4) What specific health problems have been implemented or are about to be implemented? Why?

5) How do you prepare your plans and projects?

6) What support do you receive from PLAN (advice, guidance, training, financing, other)?

7) What support would you hope to receive from PLAN now and in the future?

8) What is the composition of your organization? How are the directors chosen and elected?

9) What linkage exists between your organization and the community health workers and volunteer promoters in your community? Why? What can be done?

10) With what other institutions does your organization maintain linkages? What forms of coordination are in effect? How does PLAN support this?

11) What income-generating mechanisms or methods are being developed by the committee?

13) How can community health workers (CHWs) be motivated to continue working actively to support maternal-child health promotion and prevention activities?

GUIDELINES FOR INTERVIEWS WITH KEY COMMUNITY INFORMANTS

HEALTH PROGRAM MANAGERS

Date:___/___/__

Locale:_____ Time Started:- Time Finished.____

Name of Interviewee:_____

Position:_____ Length of Service:_____

Organization:_____

Profession: _____

1) Inter-institutional coordination, with which institutions, coordination mechanisms, results obtained:

2) Strategy for working with the community and organized community groups:

3) What technical support and resources have you received from PLAN?

4) What would you hope to receive from PLAN now and in the future?

5) How can community health workers (CHWs) be motivated to continue working actively to support maternal-child health promotion and prevention activities?

6) Does cost recovery take place in MOH health centers? How are these funds managed? Is there any administrative flexibility to permit their use at the local level?

GUIDELINES FOR INTERVIEWS WITH KEY COMMUNITY INFORMANTS

CONASUMI PARTICIPANTS

Date: _____ / / Locale: _____

Time Started: _____ Time Finished: _____

NAME OCCUPATION LENGTH OF SERVICE COMMUNITY

1) How did this organization come into existence? Why?

2) Which organizations, and of what types, constitute its membership base?

3) What are the functions of CONASUMI?

4) Has CONASUMI been efficient in carrying out its functions? Why?

5) Does it have well-defined mechanisms for proposing, developing and financing health projects?

6) Does it work exclusively in the area of maternal-child health? Or does it have additional areas of activity?

7) What facilitating elements enhance its operation?

8) What constraints hinder its operation?

9) Is there any situation in the country or in the community that has had negative effects on the establishment of the network?

10) Is there any situation in the country or in the community that has had positive effects on the establishment of the network?

11) Inter-institutional coordination, with which institutions, coordination mechanisms, results obtained?

12) What organizations are conducting health activities in the area of Herrera and Altagracia?

SUBJECT GUIDE FOR FOCUS GROUP

DIRECT HEALTH PROVIDERS (PDS)

Date: ____/ /1995 Time Started: _____ Time Finished: _____

Place: _____

Number of Participants: M e n : - W o m e n : -

NAME OCCUPATION YEARS OF SERVICE ORGANIZATION

FACILITATING FACTORS, CONSTRAINTS, TRAINING

1) What facilitating elements can be used to develop your health care activities?

2) What constraints will affect development of your health care activities?

3) Have you received training in maternal-child health? In what topics have you received training? When did you last receive training? Who sponsored that training? What area(s) did the training cover?

SOCIAL PROMOTION AND COMMUN-ITY EDUCATION

4) What IEC activities have you conducted as part of the CS IX?

5) How has the educational materials testing and production process been carried out? Are these materials both simple and useful?

6) What value do you, the PDSs and community assign to these materials?

7) How are educational activities carried out? Are they participative or traditional in nature?

8) How is the level of learning of the people of your community evaluated with regard to these materials and techniques?

SUPPLIES AND MATERIALS FOR LOCAL PERSONNEL

9) What materials and supplies are considered essential for you as direct health providers, broken down by CS intervention?

10) Have these materials been made available to you on a timely basis? In appropriate amounts? Why?

QUALITY

11) How has the CS IX identified your training needs, knowledge and skills or abilities as health providers, for properly carrying out CS interventions?

12) How have the knowledge and skills of mothers, CHWs and health providers been evaluated?

13) Does cost recovery take place in the health centers? How are these funds managed? Is there any administrative flexibility to permit their use at the local level?

EVALUATION OF COORDINATION WITH COUNTERPARTS

14) What cooperative activities have been carried out? Exchange of materials, personnel, financing, training, etc.

15) What linkage exists between you and the PLAN THAs?

16) What relationship do you have with the CHWs and other community volunteers?

17) What has been the extent of the progress achieved in the "Linkages between Health Providers in the Area of PLAN/Santo Domingo" proposal? Show graphic.

18) What incentives could strengthen participation by CHWs and other community volunteers in health activities?

19) What have you received from PLAN (technical advice, training, logistical support, etc.)?

20) How can PLAN support you in strengthening your activities in the area of maternal-child health and other related activities?

23) Do the staff working in the organizations that you represent have the technical and administrative capability to assume responsibility for CS IX activities?

SUBJECT GUIDE FOR FOCUS GROUP

CARING MOTHERS CLUBS (CMC)

Date: _____/ / Time Started: _____ Time Finished: _____

Place: _____

NAME OCCUPATION LENGTH OF TIME IN CMC COMMUNITY

ACTIVITIES, ORGANIZATIONS, FACILITATING FACTORS, CONSTRAINTS, TRAINING

1) What activities do you carry out as a member of the CMC?

How is the Club organized?

Are there requirements for belonging to the Club?

2) What facilitating elements can be used to develop your activities?

3) What constraints will affect development of your activities?

4) What have you received from PLAN (technical advice, training, logistical support, salaries, payments, etc.)?

5) Have you received training in maternal-child health? In what subjects have you received training? When did you last receive training? Who sponsored that training? What area(s) did the training cover?

ASSESSMENT OF BASIC KNOWLEDGE

6) DIARRHEA

Critical signs (dehydration, mucus, blood)
State the three most important things for treating diarrhea at home (increase liquids/oral solution/continue BF, continue feeding, monitor critical signs for possible referral)

7) ARI

Signs and/or symptoms suggesting pneumonia

8) VACCINES

Identify the vaccination scheme that should be applied to a child (which vaccines and at what ages)

9) NUTRITION AND BF

What type of nourishment should a pregnant women receive, in terms of amount and quality

What nourishment should the child receive during his first year of life (first 4 to 6 months, exclusive BF; thereafter, complementary nourishment in addition to BF)

SOCIAL PROMOTION AND COMMUNITY EDUCATION

10) What value do you and the people of your communities assign to the PLAN CS IX educational materials?

11) How are educational activities carried out? Are they participative or traditional in nature?

12) What has the CS IX done to encourage family participation and to ensure that families receive increased benefits from CS IX services and activities?

13) What linkages exist between yourselves and the health facilities operated by the MOH and other organizations sponsoring health projects in your community?

14) What relationship do you have with the PLAN CHWs and other organizations that conduct health projects in your community?

SUPPLIES AND MATERIALS FOR LOCAL PERSONNEL

15) What materials and supplies are considered essential for the activities that you carry out?

16) Have these materials been supplied to you in a timely fashion? In appropriate amounts? Why?

17) What incentives would you like to have to motivate you to continue your work as CMCs in your community?

EVALUATION OF MATERIALS, EQUIPMENT AND DRUGS FOR CHILD SURVIVAL ACTIVITIES IN HEALTH FACILITIES

Date: ____ / /

Health Facility: _____

Community: _____

Institution/Organization: _____

What is the average number of patients seen per day/week?

Outpatient _____

Emergency _____

How many patients were seen yesterday?

	O.P.	Emerg.
Total		
Women age 15-49	_____	_____
Children under age 1	_____	_____
1-4 years-	_____	_____

I. SUPPLIES OF EDUCATIONAL MATERIALS:

1.1 CDD/ORT:

Posters: _____ PLAN- OTHER-

Brochures: _____ PLAN__ OTHER-

Flipcharts: _____ PLAN- OTHER-

Other: _____ PLAN- OTHER-

1.2 CARI:

Posters: _____ PLAN- OTHER-

Brochures: _____ PLAN- OTHER-

Flipcharts: _____ PLAN- OTHER-

Other: _____ PLAN- OTHER-

1.3 BF:	Posters: _____	P L A N - O T H E R -
	Brochures: _____	P L A N - O T H E R -
	Flipcharts: _____	P L A N - O T H E R -
	Other: _____	P L A N - O T H E R -
1.4 EPI:	Posters: _____	P L A N - O T H E R -
	Brochures: _____	P L A N - O T H E R -
	Flipcharts: _____	P L A N - O T H E R -
	Other: _____	P L A N - O T H E R -
1.5 NUTRITION:	Posters: _____	P L A N - O T H E R -
	Brochures: _____	P L A N - O T H E R -
	Flipcharts: _____	P L A N - O T H E R -
	Other: _____	P L A N - O T H E R -
1.6 PRENATAL C. :	Posters: _____	P L A N - O T H E R -
	Brochures: _____	P L A N - O T H E R -
	Flipcharts: _____	P L A N - O T H E R -
	Other: _____	P L A N - O T H E R -

OBSERVATIONS: _____

_____

_____

II. SUPPLIES OF MATERIALS FOR INSTALLING NUTRITIONAL EDUCATION CENTERS (FUCESIALTAGRACIA, BARRIO HOLGUIN/LIBERTADOR WOMEN'S GROUP):

III. DRUGS:

3.1 CDD/ORT:	ORS_____	PLAN- OTHER-
3.2 CARI:	COTRIMOXAZOLE/TMP-SMX	PLAN- OTHER-
	AMOXICILLIN_____	PLAN- OTHER-
	BENZATINE_____	PLAN- OTHER-
	PARACET./ACETAM._____	PLAN- OTHER-
3.3 NUTRITION:	VITAMIN A PEARLS 50,000 UDS_____	PLAN- OTHER-
	VITAMIN A PEARLS 200,000 UDS_____	PLAN- OTHER-
	VITAMIN A PEARLS 1,000 UDS _____	PLAN- OTHER-
3.4 PRENATAL C . :	MULTIVITAMINS_____	PLAN- OTHER-
	FOLIC ACID_____	PLAN- OTHER-
	CALCIUM_____	PLAN- OTHER-

6. How are cases of coughing and respiratory difficulty classified in accordance with the new PAHO/WHO scheme (decision card)?

a) Light, moderate, serious [ ]
b) High and low [ ]
c) Very serious illness, serious pneumonia, pneumonia, cough or cold [ ]
d) None of the above [ ]

7. A child between 2 months and 11 months old is said to have rapid breathing when respiratory frequency is. . .

a) 30 or more Cl
b) 40 or more [ ]
c) 50 or more [ ]
d) 60 or more [ ]
e) 70 or more [ ]

Pedrito, a one-month-old child comes to the health center with a cough. The examination reveals normal temperature, respiratory frequency of 62 per minute, signs of rib in-drawing and that the child is breastfeeding satisfactorily.

8. Pedrito's breathing is.. .

a) Normal [ ]
b) Rapid [ ]
c) Slow [ ]

9. The probable diagnosis is.. .

a) Cough or cold Cl
b) Pneumonia [ ]
c) Serious pneumonia [ ]
d) Very serious pneumonia [ ]
e) Light ARI [ ]
f) Moderate ARI [ ]

10. Pedrito should.. .

a) Be referred immediately to a hospital [ ]
b) Be treated at home with cotrimoxazole [ ]
c) Continue breastfeeding [ ]
d) Be kept wrapped in warm clothing [I
e) Be kept with his nasal passages cleared [ ]

ANNEX6
LINKAGES BETWEEN HEALTH PROVIDERS IN THE AREA OF PLAN/SANTO DOMINGO

Linkages between health providers in the Area. PLAN/Santo Domingo